

The Honorable John C. Coughenour

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT SEATTLE

A.H. by and through G.H. and L.C., both
individually, and on behalf of the MICROSOFT
CORPORATION WELFARE PLAN, and on
behalf of similarly situated individuals and
plans,

Plaintiff,

v.

MICROSOFT CORPORATION WELFARE
PLAN; and MICROSOFT CORPORATION,

Defendants.

No. C17-01889 JCC

DECLARATION OF GEOFFREY
SIGLER IN SUPPORT OF
DEFENDANTS' MOTION TO DISMISS
UNDER RULE 12(b)(6)

Noted for Consideration:
Friday, April 27, 2018

**DECLARATION OF GEOFFREY SIGLER IN SUPPORT OF
DEFENDANTS' MOTION TO DISMISS UNDER RULE 12(b)(6)**

I, Geoffrey Sigler, declare as follows:

1. I am an attorney with the law firm of Gibson, Dunn & Crutcher LLP. My firm represents Defendants Microsoft Corporation and Microsoft Corporation Health Plan in this action. I make this declaration in support of Defendants' Motion to Dismiss. I have personal knowledge of the facts stated herein and, if called to testify, I could and would competently testify to these facts.

2. Plaintiff attached as Exhibit A to his Amended Complaint a portion of the 2016 Microsoft Corporation Welfare Plan Summary Plan Description ("2016 SPD"), effective January 1, 2016 to December 31, 2016 (Dkt. 25-1). Pages 91-329 of the 2016 SPD were not included in Plaintiff's Exhibit.

3. My firm obtained a complete, true, and correct copy of the 2016 SPD from Microsoft. This complete, true, and correct version is attached as Exhibit A to this Declaration.

4. Exhibit A has been marked in accordance with the Local Rules.

I declare under penalty of perjury that the foregoing is true and correct. Executed on April 2nd, 2018.

s/ Geoffrey Sigler
GEOFFREY SIGLER

CERTIFICATE OF SERVICE

I hereby certify that on April 2nd, 2018, I electronically filed the foregoing with the Clerk of the Court using the CM/ECF system, which will send notification of such filing to those attorneys of record registered on the CM/ECF system. All other parties (if any) shall be served in accordance with the Federal Rules of Civil Procedure.

DATED this 2nd day of April, 2018.

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Exhibit A



2016 Summary Plan Description



Looking for something?

There are three ways to navigate this document:

- Click Navigation Pane from the View toolbar.
- Type CTRL+F to search for a term or phrase.
- CTRL+Click to follow links to other sections or resources.

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Introduction

Microsoft provides industry-leading benefits to help you and your family get and stay well, prepare for your future, and enjoy life's journey. Whether you are expecting a new child, looking for some legal advice for a new home, or managing a health condition, Microsoft is here to support you with benefits and resources to help you live life well.

This Summary Plan Description (SPD) provides details of the health and welfare benefits available to eligible employees and their eligible dependents.

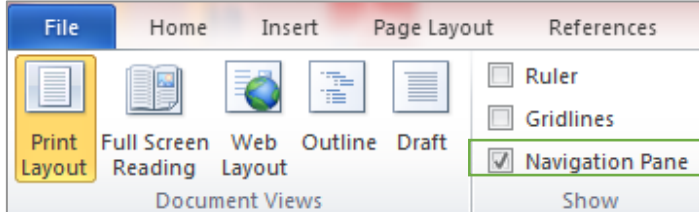
Navigating the SPD

Throughout this document, words and phrases in blue have links to additional information, either within or outside of the SPD.

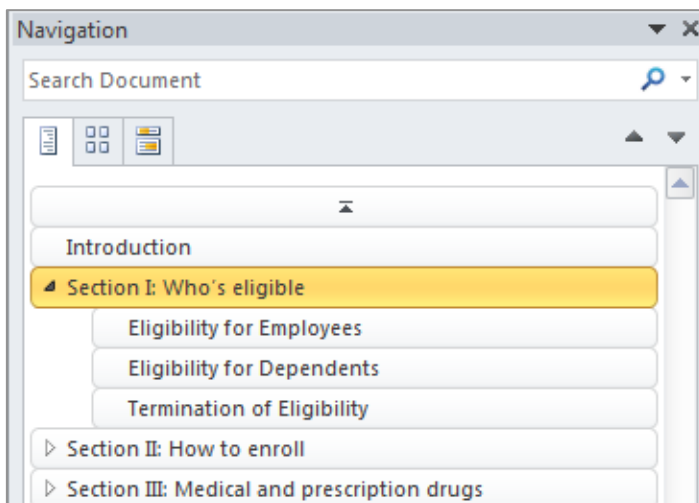
From the Table of Contents, simply CTRL+Click on the topics to go directly to your section of interest.

You can also use the navigation pane to search for terms or navigate between document sections.

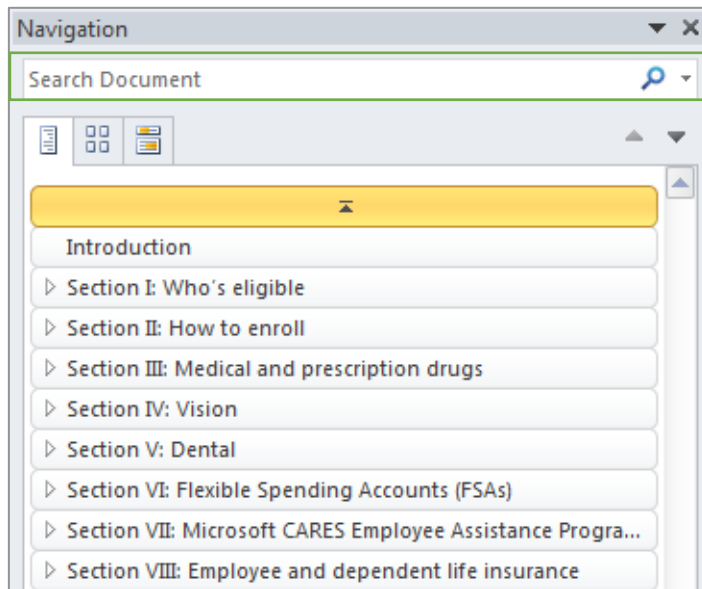
- To open the Navigation pane, press Ctrl+F, or click **View > Navigation Pane**.



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- To search the document, type a word or term into the search box at the top of the navigation pane



About the SPD

This document is intended to serve as a Summary Plan Description (SPD) as defined by the Employee Retirement Income Security Act of 1974 (ERISA) for such programs described within that are governed by ERISA. It provides many, but not all, of the details of Microsoft benefit plans. If there should be any difference between this document and the official text of the plan documents, trust agreements, and insurance contracts, the official text will always be considered correct and will govern.

Receipt of this document is not a contract

While Microsoft provides a benefit program for its employees and their eligible dependents, this benefit program does not constitute a contract of employment with Microsoft, nor does it mean future employment for Microsoft is guaranteed.

Benefits may be amended or terminated

While Microsoft expects to continue the benefits described in this document, benefits may be added, changed, and/or discontinued by Microsoft. You will be notified of any benefits changes. The benefits featured in this document are listed in the Table of Contents above.

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Eligibility

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For employees


You are eligible for benefits if you are a full- or part-time employee on the Microsoft U.S. payroll, an intern, or a visiting researcher, and are not an employee of Microsoft Store. For additional details, please review the full definition of [eligibility](#) and the explanation of [workers who are not eligible](#) for coverage.



You are on the **Microsoft U.S. payroll** if you are paid from the Microsoft Payroll department located in the United States and Microsoft withholds and pays U.S. employment taxes on your payroll amounts.

If you meet the following criteria, you are eligible to participate only in the Hawaii Only Plan (Premera) for medical coverage, even if you do not meet the definition of an eligible employee set forth earlier:

- An employee of Microsoft on the Microsoft U.S. payroll
- Reside in Hawaii
- Have completed four consecutive weeks of service as an employee of Microsoft during which you worked at least 20 hours each week.



Additional eligibility requirements may apply to certain benefits. Please review the benefit sections of this SPD for more information.

If you are rehired by Microsoft

If you are rehired by Microsoft (and again become an eligible employee) during the same plan year and within 30 days of your previous termination of employment, your election in effect at the time of termination will be reinstated. You will not be permitted to make new benefit elections solely based upon the termination and rehire. If more than 30 days have passed since your previous termination of employment, you must reenroll as a new hire and make new benefit elections.

If you transfer from another Microsoft plan

If you transfer directly from another plan sponsored by Microsoft without a lapse in coverage, the benefits of this plan will begin without any loss.

If both you and your spouse/domestic partner work for Microsoft

Certain rules apply if both you and your spouse/domestic partner work for Microsoft and are both eligible for Microsoft benefit coverage:

- For medical, vision, and dental benefits you may elect *one* coverage option:
 - You may enroll in your own coverage, OR
 - You may enroll as a dependent in your spouse's/domestic partner's Microsoft coverage, but not both.
- For life insurance and accidental death and dismemberment (AD&D) benefits you have *two* coverage options:
 - You may enroll in your own coverage, AND
 - You may also be enrolled for dependent coverage through your spouse/domestic partner
- An eligible child of two legally married employees or eligible domestic partners employed by Microsoft can be enrolled only under one employee's medical, vision, and dental benefit coverage. If a couple has two children, one employee could cover one child and the other spouse or eligible domestic partner could cover the other child on their plan.



If you and your spouse/domestic partner both work for Microsoft and enroll for coverage in the Health Savings Plan (Premera), be sure to review the additional rules that apply to Health Savings Account contributions and eligibility. Please review the [Health Savings Account](#) section for more information.

Workers who are not eligible for coverage

The following persons are not eligible to participate in the plan even if they meet the definition of a regular employee of Microsoft outlined in the prior section:

- Cooperatives
- Apprentices
- Nonresident aliens receiving no U.S. source income from Microsoft
- Employees covered by a collective bargaining agreement resulting from negotiations with Microsoft in which retirement benefits were the subject of good faith bargaining and participation in this plan was not provided for
- Persons providing services to Microsoft pursuant to an agreement between Microsoft and any other individual or entity, such as a staff leasing organization (leased employees)
- Temporary workers engaged through or employed by temporary or leasing agencies
- Temporary employees. For purposes of the plan, a temporary employee is one who is hired by Microsoft as an employee to work on a specific project or series of projects that in total is not expected to exceed six months.
- Workers who hold themselves out to Microsoft as being independent contractors or as being employed by or engaged through another company while providing services to Microsoft
- Project-based employees. For purposes of the plan, a project-based employee is one who is hired to work on a project or series of projects, is employed for a limited term, and has signed a Project-Based Employment Agreement.

For dependents

If you enroll for coverage, you may also enroll your eligible dependents for medical, vision, dental, dependent life insurance, and accidental death & dismemberment (AD&D) coverage under the plan.

Your eligible dependents include your:

Spouse	You must be married to an employee (whether same or opposite sex of the employee) under the laws of any U.S. or foreign jurisdiction having the legal authority to sanction marriages, and not legally separated
Domestic partner	<p>You and your domestic partner (either of the same or opposite sex) must meet all of the following requirements:</p> <ul style="list-style-type: none"> • You are each other's sole domestic partner and intend to remain so indefinitely • Neither of you is legally married • You are both at least 18 years of age and are mentally competent to consent to contract • You are not related by blood to a degree of closeness that would prohibit legal marriage in the state in which you legally reside • You reside together in the same residence and intend to do so indefinitely (excepting a temporary residence change of not more than 90 days during which you and your domestic partner reside in separate homes) • You are mutually responsible (financially and legally) for each other's common welfare <p>For life and accidental death & dismemberment (AD&D), a domestic partner includes any person who satisfies the requirements for being a domestic partner, registered domestic partner, or civil union partner of an eligible employee under the law of your jurisdiction of residence.</p>
Dependent children under age 26	<p>Includes your:</p> <ul style="list-style-type: none"> • Biological child and/or your spouse's/domestic partner's biological child • Child for whom you or your spouse/domestic partner has been named legal guardian as appointed by the courts (or recognized as guardian by the state of residence) • Legally adopted child, or child who has been placed with you for adoption, but not a foster child <p>A child's eligibility as a dependent does not rely on the child's financial dependency (on you or any other person), residency with you or with any other person, student status, employment, eligibility for other health plan coverage, or any combination of these factors.</p>
Incapacitated dependent children age 26 or over	<p>An incapacitated dependent is unable to sustain employment due to a developmental disability or physical handicap that existed before the child reached age 26. The individual is chiefly dependent on the member for support.</p> <p>Proof of incapacity must be submitted to the plan administrator:</p> <ul style="list-style-type: none"> • For Premera Blue Cross or Group Health Cooperative, within 90 days of the latest of the child's 26th birthday or your date of hire, and then annually thereafter • For Kaiser Permanente, within 60 days after receiving notice from Kaiser



You may be required to provide evidence of your partnership in connection with a plan audit of dependent eligibility or a claim for benefits. If desired, you may sign the [Microsoft Affidavit of Domestic Partnership](#) before a notary and retain the affidavit in your records.



Important note about tax consequences of partner benefits

Partners generally do not qualify as spouses or dependents for federal income tax purposes. Therefore, the value of company-provided medical, dental, and vision coverage that relate to your partner, or your partner's children, generally will be considered imputed income and will be taxable to you on each paycheck that the benefits are maintained. This value is subject to change from year to year as the underlying benefit values change. Tax and other withholdings will be made from your paycheck and the value of those benefits will be included in your Form W-2. During any period in which partner benefits that have an imputed income are maintained by you but you are not receiving a paycheck from the company, the company reserves the right to collect the employee FICA tax liability directly from you. These rules will not apply if your partner satisfies the requirements to be considered your tax dependent under the Internal Revenue Code or state tax laws governing state income tax.



Coverage for a child may be provided as the result of a Qualified Medical Child Support Order (QMCSO). This is an order or judgment from a court or administrative body directing the plan to cover the child of a member as required by applicable law. The written procedures for determining whether an order meets the requirements of a QMCSO may be obtained at QDRO free of charge by contacting 1-800-527-8481. Once the Plan confirms the QMCSO, coverage will begin the first day of the pay period in which the Plan receives the order unless another date is specified in the order. For more information, or to request the requirements for whether an order meets the requirements of a QMCSO, call 1-800-527-8481.

Family members who are not eligible for coverage

The following is a list of dependents who are commonly mistaken as eligible dependents. This is not an all-inclusive list but rather common examples of ineligible dependents:

- Legally separated spouse, regardless of whether you are subject to a court order or agreement requiring you to provide him/her with health care coverage
- Divorced spouse, regardless of whether you are subject to a court order or agreement requiring you to provide him/her with health care coverage
- Parents, except those that participate in the Expert Medical Opinion (Best Doctors) program, and grandparents, regardless of whether they live with you and/or depend on you for financial support. see [Expert Medical Opinion \(Best Doctors\) Program](#) for more information
- Siblings, regardless of whether they live with you and/or depend on you for financial support
- Nieces, nephews, and grandchildren, regardless of whether they live with you and/or depend on you for financial support unless they meet the dependent eligibility definition described above
- Roommates
- Foster children
- Any person who is on active duty in the armed forces
- Anyone else who does not meet the definition of an eligible dependent
- Anyone for whom you fail to provide proof of eligible dependent status, if requested

When eligibility ends

Your eligibility for Microsoft benefits ends with the last day of your employment at Microsoft.

Eligibility for your dependents ends when your eligibility ends, or earlier if your dependent no longer meets the definition of an eligible dependent. In the event of your death, eligibility for your covered dependents ends:

- The end of the month if you die before the 15th of the month
- The 15th of the next month if you die on or after the 15th of the month

Dependent children remain covered on the plan through the end of the month in which they turn 26.



Please review the [Coverage if you leave Microsoft](#) section for information on when coverage ends and your options for continuing coverage.

Leaves of absence

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Health benefits

You may be eligible for medical, prescription drug, vision and dental benefits while you are on an approved leave of absence as designated by the applicable Microsoft leave of absence policy.



To learn more about coverage during an approved leave of absence, review the [leave of absence policies](#) on the Benefits site.



Your coverage will remain in effect while you are on a leave of absence that complies with the Family and Medical Leave Act (FMLA).

If your eligibility for health benefits ends while you are on leave of absence (for example, where a personal leave of absence of more than 12 weeks is approved), you and your dependents may be eligible to continue coverage through COBRA provisions. Please review the [Coverage if you leave Microsoft](#) section for more information.

Other benefits

Your eligibility for other benefits during a leave of absence is described below.

Benefit	Eligibility on leave
Health Savings Account	Payroll deductions will continue while you are on a paid leave of absence. For unpaid leaves of absence, payroll deductions that would have otherwise been taken during that period will be deducted from your first paycheck upon your return to work. You may be reimbursed for eligible health care expenses during a paid or unpaid leave of absence.
Health FSA	Payroll deductions will continue while you are on a paid leave of absence. For unpaid leaves of absence, payroll deductions that would have otherwise been taken during that period will be deducted from your first paycheck upon your return to work. You may be reimbursed for eligible health care expenses during a paid or unpaid leave of absence.
Dependent care FSA	Payroll deductions will continue while you are on a paid leave of absence. For unpaid leaves of absence, payroll deductions that would have otherwise been taken during that period will be deducted from your first paycheck upon your return to work. Your eligibility to be reimbursed for eligible dependent care expenses depends upon your particular leave situation. For more information, refer to IRS Publication 503.
Microsoft CARES employee assistance program (EAP)	You are eligible for EAP coverage while you are on an approved leave of absence up to the limits that apply to health coverage described above.
Employee and dependent life insurance	You are eligible for employee and dependent life insurance coverage while you are on an approved leave of absence. Payroll deductions will continue while you are on a paid leave of absence. For unpaid leaves, payroll deductions that would have otherwise been taken during that period will be deducted from your first paycheck upon your return to work.
Accidental death & dismemberment(AD&D)	You are eligible for AD&D insurance coverage while you are on an approved leave of absence. Payroll deductions will continue while you are on a paid leave of absence. For unpaid leaves, payroll deductions that would have otherwise been taken during that period will be deducted from your first paycheck upon your return to work.
Long-term disability (LTD)	Imputed income deductions for LTD continue while you are on paid leave of absence. Imputed income for LTD benefits is not deducted while on an approved long-term disability leave. If you are on unpaid leave, imputed income for LTD that would have otherwise been taken during that period will be deducted from your first paycheck upon your return to work.
Group legal	You are eligible for group legal coverage while you are on an approved leave of absence. Payroll deductions will continue while you are on a paid leave of absence. For unpaid leaves, payroll deductions that would have otherwise been taken during that period will be deducted from your first paycheck upon your return to work.

If you have other health coverage (Coordination of Benefits)

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How Coordination of Benefits (COB) works

If you or your covered dependents have health benefit coverage through another employer, a government plan or Medicare, your Microsoft health plan will coordinate payments to ensure the total paid by both plans will not exceed the total amount charged. Review the following section, COB with other health plans, for more information.

If you or your covered dependents receive payments for health care from other sources, such as motor vehicle or liability insurance, your Microsoft health plan will seek to be reimbursed for benefits paid under the plan or take over your right to receive payments from the other party—this is called subrogation. Review the [COB with other types of insurance](#) section for more information.

All of your Microsoft health benefits—medical, prescription drugs, dental, and vision—are subject to these provisions.

Examples

- Mike works for Microsoft. His wife, Lee, is covered as a dependent on Mike's Microsoft medical plan but also has coverage under her employer's medical plan. Lee's plan would provide primary coverage for her and would coordinate benefits with Mike's plan.
- Jen is in a car accident with her kids. They are injured in the accident and incur health care expenses that will be paid by the other driver's vehicle insurance. The Microsoft plan will pay any remaining expenses after the vehicle insurance has been exhausted.

COB with other health plans

The Microsoft health plan will coordinate coverage with other health plans, including:

- Medicare A or B
- A plan sponsored by one or more employers or employee organizations
- A government-sponsored program other than workers' compensation

One health plan determines eligible benefits first and is considered primary and then the other health plan determines its share of the remaining balance and is considered secondary. Microsoft uses certain rules to determine which plan is primary and which is secondary, as described below.



Health plans provide medical, prescription drug, dental, or vision coverage.

The primary plan is the health plan that pays benefits first.

The secondary plan is the health plan that pays the balance for eligible expenses, subject to its plan benefits and limitations.



Due to IRS regulations, specific rules apply to the Health Savings Account if you have other plan coverage. Please review the [Health Savings Account](#) section of this SPD for more information.

If both you and your spouse/domestic partner work for Microsoft

If both you and your spouse/domestic partner are employed by Microsoft, you may not enroll for employee coverage and also be enrolled as a dependent on your spouse/domestic partner's coverage. You can each enroll in your own separate coverage with Microsoft or one of you can enroll as a dependent under your spouse's/domestic partner's coverage. Children may be enrolled as a dependent only on one Microsoft employee's coverage.

If your spouse/domestic partner has coverage through another plan

If your spouse/domestic partner is eligible for health coverage through his or her employer, you must notify Microsoft of your decision to coordinate coverage between that plan and the Microsoft plan when you enroll. Your spouse/domestic partner can do one of the following:

- Enroll in his or her employer's health plan and use Microsoft coverage as the secondary plan at no charge
- Waive the coverage available through his or her employer and enroll as a dependent on your Microsoft plan; in this case, you will pay \$75 per pay period to use the Microsoft plan as your spouse's/domestic partner's primary coverage



This policy affects only employees whose spouse/domestic partner is eligible for health coverage through his or her employer. It does not affect the following groups:

- Employees who do not have a spouse/domestic partner
- Employees whose spouse/domestic partner is not employed
- Employees whose spouse's/domestic partner's employer does not provide a health plan
- Employees whose spouse/domestic partner is not eligible for his or her employer's health plan
- Eligible dependent children enrolled in a Microsoft health plan
- Employees and spouses/domestic partners who are both employed by Microsoft and one is enrolled as a dependent on the other's plan

When Microsoft is primary or secondary

Microsoft uses the following rules to determine if the Microsoft plan is primary or secondary to other coverage.

Medicare

In most cases, the Microsoft plan is primary to Medicare, except if you are eligible for Medicare due to end stage renal disease (after the first 30 months) or disability. Your Microsoft plan will coordinate benefits with Medicare as required by federal law.



Visit the online guide Medicare and Other Health Benefits or call the Medicare Coordination of Benefits Contractor (COBC) at (800) 999-1118 (TTY users should call (800) 318-8782) for information about how Medicare coordinates coverage with other health plans.

Other plans

For Microsoft employees, the Microsoft plan is always primary to other coverage, including coverage under your spouse/domestic partner's plan, COBRA, Medicaid, and TRICARE medical. Any no-fault medical coverage for motor vehicles and boats, including Medical Payment (MEDPAY), Personal Injury Protection (PIP), Medical Premises (Medprem) for homeowners' or commercial properties or excess accident and athletic policies, will be primary to the Microsoft plan.

For your spouse/domestic partner who has other coverage, the Microsoft plan is secondary unless the following conditions apply:

- If your dependent has coverage under COBRA, Medicaid and TRICARE medical, the Microsoft plan is primary
- If your dependent has coverage under a retiree plan and the Microsoft plan, and both have a COB provision, the Microsoft plan is primary



Kaiser Permanente will coordinate benefits with the other coverage under the coordination of benefits rules of the California Department of Managed Health Care, which are incorporated in the Evidence of Coverage.

If your dependent child is covered under both parents' plans, the following rules apply:

Unless a court decree states otherwise, the rules below apply for dependent children covered by Microsoft and another plan:

- For adult dependents covered as a subscriber under their own plan or as a dependent under a spouse's plan, Microsoft will be secondary. The below rules will determine secondary and tertiary order of liability.
- Birthday Rule - When the parents are married or living together, whether or not they were ever married, the plan of the parent whose birthday falls earlier in the year is primary. If both parents have the same birthday, the plan that has covered the parent the longest is primary.
- When the parents are divorced, separated or not living together, whether or not they were ever married:
 - If a court decree makes one parent responsible for the child's health care expenses or coverage, that plan is primary.
 - If a court decree assigns one parent primary financial responsibility for the child but doesn't mention responsibility for health care expenses, the plan of the parent with financial responsibility is primary.
 - If a court decree makes both parents responsible for the child's health care expenses or coverage, the birthday rule determines which plan is primary.
 - If a court decree requires joint custody without making one parent responsible for the child's health care expenses or coverage, the birthday rule determines which plan is primary.
 - If there is no court decree allocating responsibility for the child's expenses or coverage, the rules below apply:

- The plan covering the custodial parent, first
- The plan covering the spouse/domestic partner of the custodial parent, second
- The plan covering the non-custodial parent, third
- The plan covering the spouse/domestic partner of the non-custodial parent, last
- If a child is covered by individuals other than parents or stepparents, the above rules apply as if those individuals were the parents.
- When the rules above do not establish an order, the plan that has covered the parent for the longest period of time is the primary payer.



A child of two Microsoft employees can be enrolled under only one employee's coverage.

How Microsoft pays for secondary coverage

Your dependents must follow the rules of the primary plan in order to receive secondary coverage under the Microsoft plan.

Example

Lisa works for Microsoft and her husband, Joe, is covered as a dependent on her plan. Joe's coverage through his employer is his primary plan. Joe's primary plan requires that he obtain a referral before accessing specialty care or the plan pays nothing. If Joe doesn't seek a referral, neither his primary plan nor the Microsoft plan will pay for the charge. He cannot bypass this referral requirement and submit a charge to the Microsoft plan as the secondary payer, even if the Microsoft plan does not have the same requirement for obtaining a referral.



Remember to tell your health care provider whether your Microsoft plan is primary or secondary to other coverage. This will prevent delays in receiving payment for your benefits.

If the Microsoft plan is secondary, it will pay its share of any remaining costs within plan guidelines after the primary plan has paid and the deductible in the Microsoft plan, if applicable, has been met. The plan administrator (Premera, Group Health Cooperative, or Kaiser Permanente) will review the allowable charge for the primary plan and the amount the primary plan paid.

The Microsoft plan will pay, in total, the lesser of:

- The total amount the Microsoft plan would have paid if it were primary
- The allowable charge for the Microsoft plan
- The remaining balance of your provider's bill for services covered by the Microsoft plan

Payments made by the primary plan will count toward the Microsoft plan's deductible and coinsurance limits, if applicable.

Example

Milo works for Microsoft and his domestic partner, Bo, is covered as a dependent under Milo's plan. Bo's coverage through his employer is his primary plan. Bo has a procedure that is billed at \$1,000. Bo's primary plan has an allowed amount of \$900 for this service and pays the provider. The Microsoft plan has an allowed amount of only \$700, so it does not pay any of the cost. However, \$700 is applied to Milo's deductible in the Microsoft plan because he has not met his deductible yet on the Microsoft plan.

How to submit a claim for secondary coverage

When obtaining care, your dependents with secondary coverage under the Microsoft plan will need to do the following:

- Present his or her employer's plan ID card as primary insurance
- If the provider bills secondary insurance, present the Microsoft plan ID card as well
- If the provider does not bill secondary insurance, submit the following documents to your plan administrator (Premera Blue Cross, Group Health Cooperative or Kaiser Permanente):
 - An Explanation of Benefits (EOB) statement from the primary plan
 - For medical services, an itemized bill from the provider, noting the remaining costs after payment from the primary plan
 - For prescriptions, a copy of the pharmacy receipt that includes the drug name and amount paid



Make sure to submit all claims within 12 months, even if no additional payment will be made. This will ensure that your spouse's/domestic partner's claims are applied to your deductible.

The Microsoft plan will not pay a claim submitted more than 365 days from the date of service. Employee and/or dependents will have 365 days from the date of the primary insurance Explanation of Benefits (EOB) to submit claims to the plan administrator (Premera, Group Health Cooperative, or Kaiser Permanente) for consideration. If you cannot submit the claim in a timely manner due to circumstances beyond your control, the claim will be considered by the plan administrator for payment when submitted as a formal appeal.

If your coverage under the Kaiser Permanente plan is determined to be secondary, Kaiser Permanente might be able to establish a Benefit Reserve Account for you. You may draw on the Benefit Reserve Account during a calendar year to pay for your out-of-pocket expenses for services that are partially covered by either of your coverages during that calendar year. If you are entitled to a Benefit Reserve Account, Kaiser Permanente will provide you with detailed information about this account.



For assistance with COB, please contact your plan administrator:

Premera	(800) 676-1411	<ul style="list-style-type: none"> • Medical and Dental Claim Form • Vision Claim Form • Prescription Claim Form
Group Health	(888) 901-4636	• Medical, Prescription and Vision Claim Form
Kaiser Permanente	(800) 464-4000	• Log on to kp.org to process your claims
Kaiser Permanente group numbers:		
<ul style="list-style-type: none"> • Northern California: 603873 • Southern California: 231325 		

COB with other types of insurance (Subrogation)

If another party may be liable or legally responsible to pay for a member's care, typically through another insurance plan, the Microsoft plan will seek to be reimbursed for amounts paid. The Microsoft plan may choose to:

- Subrogate—that is, take over—the member's right to receive payments from the other party. The member or the member's legal representative will transfer to the plan any rights the member might have to take legal action arising from the illness, sickness, or bodily injury to recover any sums paid under the plan on your behalf or that of your covered dependent. This is the plan's right of subrogation.
- Recover from the member or the member's legal representative any benefits paid under the plan from any payment you or your covered dependent is entitled to receive from the other party. This is the plan's right of reimbursement.

Examples

- Felicia was injured in a car accident. Felicia received payment for related health care expenses through the other driver's auto insurance policy. In this instance, the Microsoft plan may be able to recover medical expenses on the member's behalf from the auto insurer.
- Molike became ill from food poisoning. He received a payment from the restaurant for related health care expenses through a liability policy. In this instance, the Microsoft plan may be able to recover medical expenses on the member's behalf from the liability policy.



The **other party** or other parties are defined to include, but not limited to, any of the following:

- The party or parties who caused the illness, sickness, or bodily injury
- The insurer or other indemnifier of the party or parties who caused the illness, sickness, or bodily injury
- The member's own insurer (for example, in the case of Uninsured Motorist [UM], Underinsured Motorist [UIM], medical payments, or no-fault coverage, or, in the case of Personal Injury Protection – PIP, Medical Payments, or Med Pay)
- A workers' compensation insurer
- Any other person, entity, policy, or plan that is liable or legally responsible in relation to the illness, sickness, or bodily injury

Other types of insurance that may provide health coverage might include but are not limited to:

- Personal Injury Protection (PIP) coverage
- Motor vehicle medical (Medpay) or motor vehicle no-fault coverage
- Workers' compensation, labor and industry, or similar coverage
- Any excess insurance coverage
- Medical premises coverage
- Commercial liability coverage
- Boat coverage
- Homeowner policy

- School and/or athletic policies
- Other type of liability or insurance coverage

Right of reimbursement and subrogation

The following rules apply to the Microsoft plan's right of reimbursement and subrogation:

- The plan's first priority right of reimbursement will not be reduced due to the member's negligence, the member's not being made whole, or attorney's fees and costs, or due to any common fund doctrine.
- Reimbursement must be made to the Microsoft plan, regardless of whether the judgment, settlement, or other payments allocate any specified amount to reimbursement for medical expenses and regardless of whether such expenses are paid prior to or after the date of such judgment, settlement, or otherwise, and regardless whether the covered person made claim for medical expenses as part of any claim or demand.
- The Microsoft plan may seek reimbursement from any recovery, whether by settlement, judgment, mediation, arbitration, or any other recovery made by or on behalf of:
 - A covered dependent
 - The estate of any covered member, or
 - On behalf of any incapacitated member

Reimbursement will not exceed:

- The amount of benefits paid by the plan for the illness, sickness, or bodily injury, plus the amount of all future benefits that may become payable under the plan that result from the illness, sickness, or bodily injury. The plan will have the right to offset or recover such benefits from the amount received from the other party, and/or
- The amount recovered from the other party, or parties

If the member recovers payments from any of the sources identified above and fails to reimburse the Microsoft plan, the Microsoft plan may reduce future benefits from the amount received from the other party, or parties.

Working with the Microsoft health plan

The member or the member's legal representative must:

- Notify the Microsoft plan in writing whenever benefits are paid under the Plan that arise out of any injury, sickness or other condition that provides or may provide the Plan subrogation or reimbursement rights.
- Notify the Microsoft plan in writing of any terms or conditions offered in a settlement before accepting any settlement or recovery on a claim against the other party
- Notify the other party of the Microsoft plan's interest in the settlement established by this provision
- Cooperate fully with the Microsoft plan in asserting its subrogation and reimbursement rights
- Provide all information and sign and return all documents necessary to exercise the Microsoft plan's right under this provision within 14 business days of receiving a request from the Microsoft plan

If the member or the member's legal representative fails to cooperate fully as described above, they will be personally liable to the Microsoft plan for the amount paid on the member's behalf.

In the event that the Plan advances moneys or provides benefits for an injury, sickness, or other conditions, and the member recover moneys or benefits from a third party in the amount of the moneys or benefits advance; or in the event that there is a disagreement regarding reimbursement of the plan's subrogation amount at the time of settlement, the Plan has an equitable lien in connection with such amounts and the member or the member's legal representative agrees to hold any recovered funds in trust or in a segregated account for the benefit of the plan until the plan's subrogation and reimbursement rights are fully determined.



The Microsoft plan administrator has the exclusive responsibility and complete discretionary authority to control the operation and administration of this plan, with all powers necessary to enable it to properly carry out such responsibility, including, but not limited to, the power to construe and interpret the terms of this summary plan description and any other plan documentation.

Section II: Enrollment

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How to enroll

What is in this section

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When you may enroll or make changes

You may make benefit elections for you and your eligible dependents using the Benefits Enrollment tool at the following times:

- As a new employee, within 30 calendar days of your hire date
- During the annual open enrollment period in November for coverage effective the following January 1
- If you experience a qualifying life event, you can make limited changes to your benefits during the year

Otherwise, you cannot make changes to your benefit elections until the next annual open enrollment period.



You may use the [Benefits Enrollment tool](#) at any time to review your benefits information and update your beneficiary designations. The Benefits Enrollment tool lists your benefit options, the amount Microsoft pays for your coverage, and the amount (if any) you pay.



You may make changes to your Health Savings Account contributions at any time on the [Benefits Enrollment tool](#).

Charge for spouse/domestic partner medical coverage

When you enroll your eligible spouse/domestic partner for benefits, you will need to indicate whether he or she is also eligible for medical coverage through his or her employer.

There is no charge if your spouse/domestic partner is not eligible for other medical coverage. However, if he or she is eligible and waives that coverage, there is an additional charge of \$75 per pay period for coverage in a Microsoft medical plan.

The charge does not apply if your spouse/domestic partner enrolls for coverage through his or her employer and you enroll them as a dependent in a Microsoft medical plan. The Microsoft plan will coordinate payments to ensure the total paid by both plans will not exceed the total amount charged. Review the [Coordination of Benefits](#) section for more information.

If you do not indicate whether your spouse/domestic partner is eligible for other coverage when you enroll, you will automatically be charged the additional \$75 per pay period. If you and your spouse or eligible domestic partner are both employed by Microsoft and one of you waives coverage and is enrolled as a dependent under the other employee's coverage, there is no additional charge.

Taxes and your benefits

Certain benefits will be recorded as taxable income, or imputed income, in your paycheck and W-2 statement according to Internal Revenue Service (IRS) regulation, including:

- Medical and dental coverage for your same-sex spouse and children of your same-sex spouse in certain states
- Microsoft contributions to employee life insurance coverage above \$50,000
- Stay Fit health club membership, Stay Fit reimbursement, or Stay Fit annual benefit credit
- Long-term disability coverage

In addition, Microsoft contributions to your Health Savings Account (with the Health Savings Plan) are taxable at the state level in Alabama, California and New Jersey. New Hampshire and Tennessee, which do not have state income tax, have not yet exempted HSA earnings from taxes on interest or dividends.

Waiving coverage

You may waive coverage by signing on to the Benefits Enrollment tool and electing the waive coverage option during your enrollment period.

If you decide to waive medical or dental coverage, the next opportunity for you to change your coverage options will be during the next annual open enrollment period, unless you experience a qualifying status change as described in the [Qualifying life events](#) section.

What Microsoft pays for coverage

Microsoft contributes to the cost of your benefit coverage as follows:

Benefit	Microsoft contributions
Medical, vision, prescription drug	<ul style="list-style-type: none"> • Microsoft provides coverage with no monthly premium costs for you and your eligible dependents • Microsoft contributes to your Health Savings Account if you're enrolled in the Health Savings Plan (Premera)
Dental	<ul style="list-style-type: none"> • Microsoft provides coverage with no monthly premium costs for you and your eligible dependents
Microsoft CARES employee assistance program (EAP)	<ul style="list-style-type: none"> • Microsoft provides coverage for employees and eligible dependents
Life	<ul style="list-style-type: none"> • Microsoft provides employee life insurance coverage equal to two times your annual base pay up to a maximum of \$1,500,000
Long-term disability	<ul style="list-style-type: none"> • Microsoft provides long-term disability coverage equal to 60% of your pre-disability monthly earnings up to a maximum of \$15,000 per month
Stay Fit	<ul style="list-style-type: none"> • Microsoft provides the Stay Fit benefit options outlined below. All options will be considered taxable income to you. <ul style="list-style-type: none"> • Enrollment in certain health clubs in Washington state • Reimbursement of employee-only, eligible expenses up to \$800 (\$400 for employees hired on or after July 1), or • An annual benefit of \$200

First-time enrollment

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When to enroll

You have 30 days from your hire date to make your benefit elections or waive coverage using the [Benefit Enrollment tool](#). If you do not enroll within this 30-day enrollment period, you will automatically be enrolled in default coverage as described below.



During the enrollment process, you will need to designate beneficiaries for your life, accidental death & dismemberment, and long-term disability benefits.

When coverage begins

You're eligible for benefits on your hire date, and benefit coverage begins as follows:

Benefit	Coverage begins
Medical (including prescription drug and vision)	Your hire date
Dental	Your hire date
Flexible spending accounts (FSAs)	Your enrollment date
Health Savings Account (HSA)	If your coverage under the Health Savings Plan begins on the first day of the month, your HSA will be effective the same day. If your medical coverage begins after the first day of the month, your HSA becomes effective on the first day of the following month.
Microsoft CARES employee assistance program (EAP)	Your hire date
Employee and dependent life insurance	Your enrollment date (subject to satisfactory evidence of insurability (EOI) and active at work requirements for life insurance).
Accidental death & dismemberment (AD&D)	Your enrollment date
Long-term disability (LTD)	Your enrollment date
Group legal	Your enrollment date
Stay Fit	Your enrollment date

If you take no action (default coverage)

If you do not enroll or waive benefits through the [Benefits Enrollment tool](#), you will be enrolled only in the default coverage as summarized below. The costs of default coverage are paid in full by Microsoft and some coverage will result in taxable income to you. Please note that default coverage covers only the employee and does not provide coverage for your dependents.



You have 30 days from your hire date to make your benefit coverage elections. Otherwise, your next opportunity to make changes is the annual open enrollment period or if you have a [qualifying life event](#).

Benefit	Default coverage	Taxable income
Medical, vision, prescription drug	<ul style="list-style-type: none"> Medical and vision: Health Savings Plan (Premera) or, for employees whose principal residence is in Hawaii, Hawaii Only Plan (Premera) 	No
Dental	<ul style="list-style-type: none"> Dental Plus 	No
Life	<ul style="list-style-type: none"> Two times your annual base pay* 	Yes
Long-term disability	<ul style="list-style-type: none"> 60% coverage level 	Yes
Stay Fit	<ul style="list-style-type: none"> Annual benefit of \$200 	Yes

*Minimum default is \$50,000. Maximum default is \$500,000 – the highest amount allowable without evidence of insurability. The value of Microsoft contributions to employee life insurance coverage above \$50,000 is taxable income.

Open enrollment

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When to enroll

The open enrollment period is in November each year, and it is your opportunity to make changes to your benefit elections, including adding or deleting coverage for your dependents. You may review and submit any changes to your elections on the [Benefits Enrollment tool](#).

If you are on leave during the open enrollment period for the entirety or an only a portion of open enrollment, you will be notified of open enrollment by mail. You must submit any changes to your benefit elections via the Benefits Enrollment tool or the enclosed enrollment form before the end of the enrollment period.

Typically, you cannot make changes to your benefit elections outside the annual open enrollment period. However, you can make certain coverage changes during the calendar year if you have a [qualifying life event](#).



Removing a dependent during Open Enrollment is not a COBRA qualifying event so COBRA coverage will not be made available to the dropped dependent when they lose coverage on January 1st.

When coverage begins

The changes you make during open enrollment are effective the following January 1.

If you take no action

If you do not make changes to your benefit elections through the Benefit Enrollment tool, your current coverage will continue uninterrupted, except for your participation in the flexible spending accounts (FSAs). You must actively elect to participate in the flexible spending accounts each year as required by the IRS.

Life event enrollment

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When to enroll

You can make certain benefit changes outside of open enrollment if you have a qualifying life event as described below. The benefit changes must be consistent with the qualifying life event you experience, as required by Federal law. You may make changes to your Health Savings Account contributions at any time, regardless of whether or not you have experienced a qualifying life event.

If you experience one of these status changes, you must make any changes to your benefit elections using the [Benefits Enrollment tool](#) or by contacting Benefits within:

- 30 days of the event that produced the change in status, or
- 60 days for divorce or legal separation, or
- 90 days of the event for a marriage, the establishment of a domestic partnership, birth or legal adoption (or placement for adoption) of a child or a child of a domestic partner



You may not change your elections in the following benefits outside of the annual open enrollment period:

- Employee life insurance
- Long-term disability (LTD)
- Group legal
- Stay Fit

If you have default coverage, in addition to the above, you may not make changes to dependent life insurance or dependent AD&D insurance except during the open enrollment period.



Removing a dependent during Open Enrollment is not a COBRA qualifying event so COBRA coverage will not be made available to the dropped dependent when they lose coverage on January 1st.

Qualifying life events

Special enrollment events

Under the Health Insurance Portability and Accountability Act (HIPAA), you may change your medical (including prescription drug and vision) or dental coverage if you lose other coverage or acquire a spouse or dependent. Though not required by HIPAA, Microsoft allows equivalent arrangements for domestic

partners and their children if they are otherwise eligible for coverage. These special enrollment events include:

- Your marriage or establishment of your domestic partnership
- The birth or legal adoption (or placement for adoption) of a child, or a child of your domestic partner
- You or your eligible dependent becomes eligible for assistance under a Medicaid or state child health plan
- The loss of other health coverage by you or your eligible dependent, for example:
 - The exhaustion of COBRA coverage
 - The loss of eligibility due to change in employment
 - The end of employer contributions, resulting in a higher cost of coverage
 - The loss of eligibility for coverage under a Medicaid or state child health plan

If you experience a special enrollment event, you may make the following changes, as long as these changes are due to and consistent with the reason for the status change:

- Add medical (including prescription drug and vision) or dental coverage for yourself or your eligible dependents
- Change medical coverage options
- Begin, increase, decrease, or end participation in the flexible spending accounts (FSAs). (If you increase your FSA contribution, you may not be reimbursed for eligible expenses beyond your prior contribution if they occurred before the change.)
- Add or delete dependent life insurance coverage
- Increase/decrease employee life insurance coverage
- Add or change between employee and family tier accidental death and dismemberment (AD&D) coverage if you are currently enrolled. (The multiple of pay amount of AD&D coverage cannot be changed if already enrolled.)

Other life events

If you experience any of the following life events, you may be eligible to make limited benefit changes for yourself or your eligible dependents.

- A divorce, legal separation, or an annulment, or the dissolution of your domestic partnership
- The death of an eligible dependent
- A change for dependent child's status such that they satisfy, or no longer satisfy, the requirements for dependent status
- A change in employment for you or your spouse/domestic partner, even if this change does not affect your eligibility for coverage (gain or loss of job, change in hours worked, taking or returning from unpaid leave)
- A change of residence for you or your eligible dependent (for example, an interstate transfer that results in a change of eligibility for a medical plan)
- You or your eligible dependent become eligible for Medicare or Medicaid
- The issuance of a qualified medical child support order (QMCSO) with respect to the health coverage for your eligible dependent child
- A significant change in dependent care cost or coverage for you or your spouse/domestic partner



You may be eligible to make limited benefit changes for certain life events, but you are required to remove your dependent in the case of a divorce, legal separation, annulment, or the dissolution of your domestic partnership.

If you experience one of these other life events listed above, you may make changes to the following benefits, as long as these changes are due to and consistent with the reason for the status change:

- Add medical (including prescription drug and vision) or dental coverage for yourself
- Add or delete medical (including prescription drug and vision) or dental coverage for your eligible dependents
- Begin, increase, decrease, or end participation in the flexible spending account (FSA). (If you increase your FSA contribution, you may not be reimbursed for eligible expenses beyond your prior contribution if they occurred before the change.)
- Add or delete dependent life insurance coverage
- Increase/decrease employee life insurance coverage
- Add or change between employee and family tier accidental death and dismemberment (AD&D) coverage if you are currently enrolled. (The multiple of pay amount of AD&D coverage cannot be changed.)



In addition to the rules above, if you are in a domestic partnership you may make changes to the dependent care or health care FSA if the change in status affects you or your child or children, but not if the change in status affects your domestic partner or your domestic partner's child or children

Examples of consistency rule

The benefit changes you make must be due to and consistent with the reason for the status change, as demonstrated in the following examples. The Benefit Enrollment tool will request information about your life event to determine which benefit changes meet IRS requirements.

Example

Jodi's (a Microsoft employee) family is covered by benefits through his wife's employer. If his wife loses her job, Jodi may make the following changes to his Microsoft benefits:

- Enroll or change coverage in medical and dental
- Enroll, change or stop coverage in the health care FSA
- Change or stop coverage in the dependent care FSA
- Enroll, change or stop spouse life insurance coverage. Enroll for child life insurance if not previously enrolled
- Enroll or change from employee only to family coverage. (He cannot change the multiple of pay level of coverage if already enrolled)

Changes are not permitted for employee life insurance, long-term disability, group legal, or Stay Fit outside of the annual open enrollment period.

Example

Terika and her partner have a baby girl. Terika may make the following changes to her benefits:

- Enroll or change medical plans, and add dependents
- Enroll in dental, and add dependents
- Enroll, increase or stop coverage in the health care FSA
- Enroll or increase coverage in the dependent care FSA
- Enroll for child life insurance if not previously enrolled (She cannot remove current child life coverage or change the level of coverage)
- Increase/decrease employee life insurance coverage
- Enroll or change from employee only to family AD&D coverage (She cannot change the multiple of pay level of coverage if already enrolled)

Changes are not permitted for employee life insurance, long-term disability, group legal or Stay Fit outside of the annual open enrollment period.

Example

Joe contributes to the dependent care flexible spending account (FSA) for his wife's son. If Joe's wife changes from full-time to part-time work, and loses eligibility for medical and dental coverage, Joe can:

- Change his contribution to the dependent care FSA
- Enroll or add dependents to the medical and dental plans
- Enroll or increase health care FSA coverage

Changes are not permitted for employee life insurance, long-term disability, group legal, or Stay Fit outside of the annual open enrollment period.

Section III: Medical and prescription drugs

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Introduction

Microsoft provides comprehensive medical and prescription drug coverage for you and your family to help you get and stay well. This introduction provides an overview of these options and common plan terms and conditions. For specific information on the plans available please refer to the section on each plan option.

Your plan options

All Microsoft employees are eligible to enroll themselves and their eligible dependents for medical coverage, which includes prescription drug and vision coverage. Microsoft pays the cost of covering you and your eligible dependents on these plans, which means you pay no premiums for coverage.

Where you live determines which plans are available to you—the Health Savings Plan is a national plan and the HMO and Hawaii Only plans are available only in specific states.

	Health Savings Plan (Premera)	Hawaii Only Plan (Premera)	Group Health Cooperative HMO Plan	Kaiser Permanente HMO Plan
Eligible employees	<ul style="list-style-type: none"> Employees in all states except Hawaii 	<ul style="list-style-type: none"> Employees in Hawaii 	<ul style="list-style-type: none"> Employees in Washington 	<ul style="list-style-type: none"> Employees in California

If you live in an area with few or no Premera in-network providers, you are eligible for Access coverage in the Health Savings Plan

If you live in an area with few or no Premera in-network providers, you will be enrolled for Access coverage in the Health Savings Plan. Access coverage provides in-network coverage for care with providers and facilities outside the Premera network. Network availability is determined by the Premera and national Blue Cross Blue Shield standard criteria. This coverage will remain in effect until a provider network is established in your area.

All of our medical plans cover services as long as they are medically necessary and provided by an eligible provider. All of the benefits for each medical plan are subject to the plan's exclusions and limitations and each benefit may have additional eligibility criteria and exclusions and limitations. Please review the following sections for each medical plan for more information on what is covered.



Visit the [vision](#) section for information about your vision coverage, which is determined by the medical plan you choose.



Medically necessary services or supplies meet certain criteria, including:

- It is essential to the diagnosis or the treatment of an illness, accidental injury, or condition that is harmful or threatening to the patient's life or health, unless it is provided for preventive services when specified as covered under the plan
- It is appropriate for the medical condition as specified in accordance with authoritative medical or scientific literature and generally accepted standards of medical practice

Review the [glossary](#) for a full definition.

How the plans work

All of the medical plans cover preventive care at 100% with in-network providers. For other care, you pay a share of the costs up to an annual maximum amount.

Each medical plan features a comprehensive network of providers and facilities where you may receive care at lower, negotiated rates. The HMO plans do not typically cover out-of-network care. The Health Savings Plan and Hawaii Only Plan cover in- or out-of-network care, but provide more value if you use in-network providers.

In-network vs. out-of-network care

If you enroll in the Health Savings Plan or the Hawaii Only Plan, you receive the highest level of coverage and have the lowest out-of-pocket costs if you seek care from any of the providers or facilities in your medical plan's network. Additional advantages of staying in-network include:

- Your provider files claims for you directly with Premera
- Lower, negotiated rates for care and prescriptions, called the allowable charge
- Your provider accepts the allowable charge as payment in full; you are not charged any additional costs



The **allowable charge** is the negotiated amount that in-network providers have agreed to accept as payment in full for a covered service. Out-of-network providers may not accept the allowable charge as payment in full.

Note: The Plan will not discriminate against a health care professional or facility that acts within the scope of its license or certification under applicable state laws when choosing in-network health care professionals and facilities.

If you seek care with an out-of-network provider or facility, services are covered at a lower out-of-network benefit level. Additional considerations include:

- You may have to pay the provider and submit a claim for reimbursement
- Coverage under the plan is limited to the allowable charge; you are responsible for any amount charged above the allowable charge

Below is an example of how much you can save through the negotiated rates that you receive with in-network providers.

Out-of-network charge	In-network charge (allowable charge)	in-network provider savings
\$150	\$100	\$50

Plan comparison

The table below compares the four medical plans on various characteristics. For complete details, please review the following sections on each medical plan.

	Health Savings Plan (Premera)	Hawaii Only Plan (Premera)	Group Health Cooperative HMO Plan	Kaiser Permanente HMO Plan
Deciding where to get care	<ul style="list-style-type: none"> You decide each time you need medical care whether to use providers who are in-network or providers who are out-of-network You can choose your doctors, including specialists. You do not need a referral to receive care. 		<ul style="list-style-type: none"> You will be required to select a Primary Care Provider for each covered family member You Primary Care Provider directs your care, including referrals to specialists 	
In-network vs. out-of-network	<ul style="list-style-type: none"> Your out-of-pocket costs vary depending on whether you use in-network providers or out-of-network providers Your costs are lower when you use an in-network provider 		<ul style="list-style-type: none"> Benefits are generally available only when utilizing the services of the HMO network providers. With few exceptions, out-of-network care is not covered 	
Cost sharing	<ul style="list-style-type: none"> You pay 100% of your eligible expenses for medical care and prescriptions until you spend up to the amount of the deductible If you reach the deductible, then you begin to pay a portion of the cost, called coinsurance, up to the coinsurance maximum. The coinsurance amount you pay depends on where you seek care in or out of network If you meet your deductible and then you reach your coinsurance maximum, the plan pays 100% of eligible expenses for the rest of the year 		<ul style="list-style-type: none"> For most services, you pay a flat copayment If you have an inpatient hospital stay, you pay 10% of the cost Coinsurance and copayments are limited by an annual out-of-pocket maximum 	<ul style="list-style-type: none"> For most services, you pay a flat copayment If you have an inpatient hospital stay, you pay 10% of the cost Coinsurance and most copayments are limited by an annual out-of-pocket maximum; prescription copayments do not count toward the out-of-pocket maximum
Filing a claim	<ul style="list-style-type: none"> If using in-network benefits, your provider will file claims to the health plan on your behalf If using out-of-network benefits, you may be required to file a claim for reimbursement of the medical expenses 		<ul style="list-style-type: none"> No claim forms required 	

	Health Savings Plan (Premera)	Hawaii Only Plan (Premera)	Group Health Cooperative HMO Plan	Kaiser Permanente HMO Plan
Coverage out of the country	<ul style="list-style-type: none"> Your benefits cover you when you travel worldwide. If you receive services outside of the Premera network you will receive coverage at the out-of-network level 		<ul style="list-style-type: none"> Coverage out-of-network is limited to emergency situations only 	



Copayment is a fixed, up-front dollar amount that you're required to pay for certain covered services.

Deductible is the amount of covered medical costs you must pay each calendar year before the plan begins to pay its share of allowable charges.

Coinsurance The percentage of the allowable charge that you are required to pay for certain covered services.

Out-of-pocket maximum is the most you could pay each plan year for covered services and supplies.



If you leave Microsoft, you may be eligible to continue your health coverage. For more information, visit the [Coverage if you leave Microsoft](#) section.

Health Savings Plan (Premera)

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Visit the [Health Savings Plan](#) section on the Benefits site for more information on how the plan works and additional resources.

How the plan works

The Health Savings Plan provides comprehensive medical coverage and the flexibility to see any provider you choose. Preventive care is covered at 100% and you pay a share of other expenses up to an annual maximum amount.

This plan features a Microsoft-funded [Health Savings Account](#) that you can use to cover eligible health care expenses. Here's how they work together:

- The Health Savings Plan is your **health insurance**, and provides coverage for health care that you might need during the year
- The Health Savings Account is basically a **bank account** that comes with certain tax benefits when you use it only to pay for health care expenses—now, or in the future

Where you can get care

With the Health Savings Plan, you have the flexibility to visit the provider or facility you choose and still have coverage. However, providers in the nationwide Premera Blue Cross Blue Shield network feature certain advantages, including:

- Your provider files claims directly with Premera
- Lower, negotiated rates for care and prescriptions
- The highest coverage levels

If you seek care with an out-of-network provider or facility, your out-of-pocket costs will be higher, and you may have to pay the provider and then submit a claim for reimbursement.

Please review the [What you pay](#) section for information on coverage levels.

Finding an in-network provider

In Washington State, you can maximize your savings by using providers and facilities in the Premera network. We have made an arrangement for you as a Premera Blue Cross member with Anthem Blue Cross in California. In order for you to maximize your savings, you will need to choose only Anthem Blue Cross network providers for services received in California.

Outside of Washington and California, you may use any Blue Cross and/or Blue Shield provider throughout the United States, the Commonwealth of Puerto Rico, Jamaica, and the British and U.S. Virgin Islands under the [BlueCard®](#) Program. Your Premera identification card tells contracting providers that you are covered through this inter-plan arrangement. It's important to note that receiving services through BlueCard does not change covered benefits, benefit levels, or any stated residence requirements of this plan.



Visit the online [Premera Medical Directory](#) to find an in-network provider in the United States.

Travel outside the United States

If you are traveling outside the United States, the Commonwealth of Puerto Rico, Jamaica and the British and U.S. Virgin Islands and need care, you may be able to take advantage of [BlueCard Worldwide®](#), which provides referrals to doctors and other health care providers.



Call (800) 810-BLUE (2583) for BlueCard Worldwide referrals to health care providers outside the United States, the Commonwealth of Puerto Rico, Jamaica, and the British and U.S. Virgin Islands.

You will need to submit claim forms to Premera for reimbursement of services received outside the United States, including services through BlueCard Worldwide. When you submit a claim, clearly detail the services received, diagnosis (including standard medical procedure and diagnosis code, or English nomenclature), dates of service, and the names and credentials for the attending provider. Benefits reimbursement will be calculated in U.S. dollars.

Care received outside the United States will be covered at out-of-network levels as long as the services are:

- Medically necessary
- Provided by a licensed provider performing within the scope of his or her license and practice
- Not deemed experimental or investigational based on the terms of this plan, or medical standards in the United States

Services received outside the United States that are considered urgent or emergent including services received on a cruise ship will be paid as [emergency care](#).



Experimental or investigational services, equipment, and drugs have not been approved by the U.S. Food and Drug Administration (FDA) for the specified use. Review the [glossary](#) for a full definition.



Please review the [What you pay](#) section for information on coverage levels.

Filling a prescription

Depending on your needs, you may fill your prescription at a retail pharmacy, pharmacy home delivery, or specialty pharmacy. Review the [prescription drug](#) benefit for more information on what is covered.



Microsoft reserves the right to change pharmacy networks at any time. Such changes will take effect on the date set by the Company, even if this information has not been revised to show the changes. Members will be given written notice in advance of such changes.

	Retail pharmacy	Home delivery	Specialty pharmacy
Coverage	<ul style="list-style-type: none"> Up to a 90-day supply for generic maintenance medication; all others are up to a 30-day supply* 	<ul style="list-style-type: none"> Up to 90-day supply* 	<ul style="list-style-type: none"> Up to a 30-day supply* Additional clinical support for members using specialty drugs
In-network pharmacies	<ul style="list-style-type: none"> Express Scripts pharmacies bill the plan on your behalf To find an Express Scripts retail pharmacy, call (800) 676-1411 	<ul style="list-style-type: none"> Express Scripts pharmacies bill the plan on your behalf 	<ul style="list-style-type: none"> Walgreens or Accredo specialty pharmacies bill the plan on your behalf
Out-of-network pharmacies	<ul style="list-style-type: none"> You will need to submit a prescription reimbursement form, with your receipt, for reimbursement 	<ul style="list-style-type: none"> You will need to submit a prescription reimbursement form, with your receipt, for reimbursement 	<ul style="list-style-type: none"> You will need to submit a prescription reimbursement form, with your receipt, for reimbursement

* Unless the drug maker's packaging limits the supply in some other way.



A **prescription drug** is any medical substance that cannot be dispensed without a prescription according to federal law. Only medically necessary prescription drugs are covered by this plan.

Generic maintenance medications have a common indication for the treatment of a chronic disease (such as diabetes, high cholesterol, or hypertension). Indications are obtained from the product labeling. They are used for diseases when the duration of the therapy can reasonably be expected to exceed one year. A generic prescription drug is manufactured and distributed after the brand-name drug patent of the innovator company has expired, and is available at a lower cost than brand-name prescriptions. Generic drugs have obtained an AB rating from the U.S. Food and Drug Administration and are considered by the FDA to be therapeutically equivalent to the brand-name product.

Specialty drugs are high-cost drugs, often self-injected and used to treat complex or rare conditions, including rheumatoid arthritis, multiple sclerosis, and hepatitis C. Specialty drugs may also require special handling or delivery. These medications can be dispensed only for up to a 30-day supply.

Prior Authorization

Prior authorization, also referred to as a pre-service review, is recommended for some services and prescriptions to determine that coverage is available before the service occurs. Either the member or the provider may contact Premiera for prior authorization.



Prior authorization is an advance determination by Premera that the service or prescription is medically necessary and that the member's plan has benefits available for the service being requested. This determination is offered in certain situations where medical records must be provided to establish medical necessity before the plan will pay for the service. Services are subject to eligibility and benefits at the time of service.

Refer to the specific plan benefit for additional details.

What you pay

You pay nothing for preventive care when you use in-network providers. When you receive care or prescription drugs in other situations, such as for the treatment of illnesses, injuries, and chronic conditions, you pay a portion of the cost up to an annual maximum amount. That annual amount, called your out-of-pocket maximum, includes a deductible and coinsurance. If you use in-network providers, you'll receive the lower Premera-negotiated rate, called the allowable charge, and higher coverage levels. Examples of how the plan pays for in- and out-of-network care follow on the next page.

What you pay			
	Deductible	+	Coinsurance = Out-of-pocket maximum
	You pay 100% of your eligible expenses for medical care and prescriptions until you spend up to the amount of the deductible. Only the Premera allowable charge is applied to your deductible if you seek out-of-network care. You pay nothing for in-network preventive care.		<p>If you reach the deductible, then you begin to pay a portion of the cost, called coinsurance, up to the coinsurance maximum. The coinsurance amount you pay depends on where you seek care:</p> <ul style="list-style-type: none"> • In-network, you pay 10% • Out-of-network, you pay 30% of the allowable charge plus the difference between the provider's bill and the allowable charge; only the allowable charge is applied to your coinsurance maximum <p>If you meet your deductible and then you reach your coinsurance maximum, you have reached your out-of-pocket maximum. From that point forward, the plan pays 100% of eligible expenses and you pay nothing for in-network health care services for the rest of the year. You will still be responsible for the difference between the provider's bill and the allowable charge if you seek out-of-network care.</p>
Employee only	\$1,500		\$1,000 \$2,500
Employee + 1	\$3,000		\$2,000 \$5,000
Employee + 2 or more	\$3,750		\$2,500 \$6,250



An **allowable charge** is the negotiated amount that Premera in-network providers have agreed to accept as payment in full for a covered service. Out-of-network providers may not accept the allowable charge as payment in full. If you choose to use out-of-network providers, only the allowable charge will apply toward your deductible, coinsurance maximum, and out-of-pocket maximum, as applicable. You are responsible for paying the difference between the allowable charge and the amount your out-of-network provider charges.

Example

Jakob needs to visit his allergist. He can choose an in-network or an out-of-network provider. Both charge \$115. The in-network provider accepts Premera's allowable charge of \$100 as full payment. Jakob hasn't yet met his deductible, so he will pay the allowable charge of \$100 to his in-network provider.

The out-of-network provider does not have the negotiated agreement with Premera, so Jakob would pay the full \$115, and only the allowable charge of \$100 would apply to his deductible.

Example

Mimi needs to see her podiatrist. The visit costs \$125 and the allowable charge is \$100. Mimi has met her deductible, so she'll pay just \$10 for her visit if she uses an in-network provider (\$100 x 10% coinsurance). If she visits an out-of-network provider, she would pay \$55:

- 30% of the \$100 Premera allowable charge (\$100 x 30% coinsurance = \$30)
- Plus the difference between the out-of-network provider's bill and the allowable charge (\$125-\$100=\$25)

Example

Kunji has an ear infection. The provider visit costs \$175 and the allowable charge is \$150. Kunji has met her out-of-pocket maximum, so she'll pay nothing if she visits an in-network provider.

If she visits an out-of-network provider, she'll pay \$25, the difference between the out-of-network provider's bill and the allowable charge (\$175-\$150=\$25)

Expenses NOT applied to the deductible or coinsurance

The following services are covered by the plan at 100% and do not count toward the deductible or coinsurance maximum.

- Preventive care
- Care received through the [Microsoft CARES employee assistance program](#)

Certain other expenses are your responsibility to pay and do not count toward the annual deductible or coinsurance maximum. They include:

- Expenses incurred while the member was not covered under the plan
- Expenses for services, supplies, settings, or providers that are not covered under this plan
- Expenses in excess of annual or lifetime benefit maximums that apply to certain plan benefits
- Amounts for out-of-network care in excess of the allowable charge for the service or supply
- Coinsurance for services covered under the [Weight Management program](#)

Additionally, charges for medical services received during business travel that are applied to the deductible or coinsurance are not a reimbursable business expense.



Visit [My Dashboard](#) on the Benefits site for information on how to track your deductible and/or coinsurance.

Out-of-network care with in-network coverage

You may seek out-of-network care and receive in-network coverage levels in the following situations:

Situation	Benefit coverage	What you need to do
Emergency care	Benefits are provided regardless of network status	Go to the nearest emergency facility
You cannot find the provider specialty that you need in the Premera network	If the Premera network does not include a provider specialty (such as a speech therapist) anywhere in your state, treatment at out-of-network providers may be paid at the in-network level	To confirm this coverage is available, please contact Premera at (800) 676-1411
Your provider's contract with Premera is ending (continuity of care)	If you are receiving ongoing treatment (such as a physical therapy) you may be eligible to continue to receive in-network benefits for the current course of treatment, for a specific time period. During any extension of in-network benefits, you may be required to pay any amounts over the allowable charge.	To confirm this coverage is available, please contact Premera at (800) 676-1411 prior to the end of your provider's contract with Premera

Annual and lifetime maximums

There is no overall annual or lifetime maximum in the Health Savings Plan. However, annual and lifetime maximums apply to certain benefits. Please review the [What the plan covers](#) section for details on annual and lifetime benefit maximums.



A **lifetime benefit maximum** is the most a plan will pay toward a benefit for a member. Review the [glossary](#) for a full definition.

Example

There is a \$15,000 lifetime infertility benefit maximum per eligible member (employee, spouse/domestic partner) and a \$6,000 weight management program lifetime benefit.

What the plan covers

The tables below summarize what the Health Savings Plan covers, including what the plan pays for in-network and out-of-network care.



Services and supplies must be **medically necessary** and are subject to all benefit exclusions and limitations and the plan's *Exclusions and limitations*.



CTRL+Click on the benefits below to access more information.

Common benefits		
These are the most commonly used benefits in the Health Savings Plan.		
Benefit	In-network coverage	Out-of-network coverage
Preventive Care Including well-child care through age 11, annual routine physical exams age 12 and up, routine gynecological exams, immunizations and preventive prescription drugs (See the Preventive Care Services list and Preventive Drug list)	Preventive services: 100% Preventive prescription drugs: 100%	Preventive services: 100% of allowable charges Preventive prescription drugs: 100%
Prescription drugs Including brand-name preventive with generic equivalent (see also preventive care below)	90% after deductible	90% after deductible
Physician services Including specialists and second surgical opinions rendered in the office, hospital, or other medical facility	90% after deductible	70% of allowable charges, after deductible
Lab tests & X-rays	90% after deductible	90% of allowable charges, after deductible
Hospital inpatient care Including semi-private room and board, anesthesia, supporting services, testing, supplies, and intensive or coronary care	90% after deductible	70% of allowable charges, after deductible
Hospital outpatient care/ambulatory surgical care center Including minor surgery, X-ray and radium therapy, anesthesia, and pre-admission testing	90% after deductible	70% of allowable charges, after deductible

Common benefits		
These are the most commonly used benefits in the Health Savings Plan.		
Benefit	In-network coverage	Out-of-network coverage
Urgent care	90% after deductible	70% of allowable charges, after deductible
Rehabilitation – Physical, Occupational and Speech Therapies	90% after deductible	70% of allowable charges, after deductible
Contraception Contraceptive devices and injections administered by a physician. Prescription forms of contraception are covered under preventive care.	100%	100%
Maternity care (Other than hospital inpatient or outpatient care)	90% after deductible	70% of allowable charges, after deductible
Mental health and chemical dependency treatment	Outpatient services through Microsoft CARES employee assistance program : <ul style="list-style-type: none"> • 100% up to three visits per member per calendar year • 100% up to three telephonic counseling sessions per member per calendar year • 100% up to eight visits per family for family or couples counseling per calendar year 	
	90% after deductible for inpatient and outpatient services	70% of allowable charges, after deductible for inpatient and outpatient services

Other benefits		
The Health Savings Plan also covers these additional benefits.		
Benefit	In-network coverage	Out-of-network coverage
Ambulance	90% after deductible	90% after deductible
Chiropractic services, acupuncture, and medical massage	90% after deductible	70% of allowable charges, after deductible
	Combined 24-visit limit per member per calendar year	
Diabetes health education	100%	100% of allowable charges
Emergency room care and professional services	90% after deductible	90% after deductible
Hearing care and hardware	Exams: 90% after deductible	Exams: 70% of allowable charges, after deductible
	Hardware: 90% after deductible; \$3,000 hardware limit per member in a period of three consecutive calendar years	

Other benefits		
The Health Savings Plan also covers these additional benefits.		
Benefit	In-network coverage	Out-of-network coverage
Home health care	90% after deductible	70% of allowable charges, after deductible
Hospice care	90% after deductible	90% after deductible
Medical equipment and supplies	90% after deductible	90% of allowable charges, after deductible
Nutritional therapy	100%	100% of allowable charges
	First 12 visits per member per calendar year, calendar year visit limit waived for nutritional therapy for a diagnosed eating disorder or diabetes.	
Skilled nursing facility	90% after deductible; up to 120 days per calendar year	70% of allowable charges, after deductible; up to 120 days per calendar year
	120-day limit per member per calendar year	
Surgical weight loss treatment Covered when criteria listed in the Premera Medical Policy on Surgery for Morbid Obesity are met	90% after deductible	70% of allowable charges, after deductible
Temporomandibular joint (TMJ) dysfunction	90% after deductible	70% of allowable charges, after deductible
Transplants	90% after deductible	70% of allowable charges, after deductible
Vision therapy	90% after deductible	70% of allowable charges, after deductible
	32-visit lifetime benefit maximum per member	

Specialized benefits		
Microsoft provides these unique benefits to you through the Health Savings Plan.		
Benefit	In-network coverage	Out-of-network coverage
Autism/Applied Behavior Analysis (ABA) therapy	90% after deductible	Not applicable
Infertility	90% after deductible	90% of allowable charges, after deductible
	Combined maximum lifetime benefit including prescription drugs of \$15,000 per member	
Transgender services	90% after deductible	90% of allowable charges, after deductible

Specialized benefits		
Microsoft provides these unique benefits to you through the Health Savings Plan.		
Benefit	In-network coverage	Out-of-network coverage
Weight Management program Including comprehensive and clinically based weight management programs approved by Premera for the treatment of obesity	80% of charges up to a maximum lifetime benefit payment of \$6,000. Deductible and coinsurance maximum do not apply. The 20% coinsurance you pay will not count toward the deductible or coinsurance maximum and will continue after the deductible and coinsurance are met.	Not applicable

Plan benefits



The following pages provide details on what the plan covers. The plan's [Exclusions and limitations](#), including the requirement of medical necessity, apply to these benefits.

Ambulance

In-network: 90%, deductible applies

Out-of-network: 90%, deductible applies

This benefit covers licensed surface (ground or water) and air ambulance transportation to the nearest medical facility equipped to treat the condition, when any other mode of transportation would endanger the member's health or safety. This benefit is limited to the member that requires transportation.

Autism/Applied Behavior Analysis (ABA) therapy

In-network: 90%, deductible applies

Out-of-network: not applicable

This benefit covers behavioral interventions based on the principles of Applied Behavioral Analysis (ABA) through eligible providers.

Who is eligible

This benefit is available for enrolled dependent children who are diagnosed with the following conditions under the Autism Spectrum Disorder:

- Autistic Disorder (International Classification of Diseases, 9th Revision, Clinical Modification)
- Childhood Disintegrative Disorder

- Asperger's Disorder
- Rett's Disorder and Pervasive Development Disorder Not Otherwise Specified/Atypical Autism
- Pervasive Developmental Disorder



- If you need assistance confirming the diagnosis your doctor provides is an eligible diagnosis for the Autism/Applied Behavioral Analysis benefit you may contact Premera Customer Service at (800) 676-1411 or email microsoft@premera.com.

Eligible providers

The benefit covers services through providers who have met established qualifications for certification (known as certified providers) and who perform services in consultation with a certified provider (known as therapy assistants).



- To find approved autism providers who are eligible for reimbursement (not including therapy assistants), review the [Certified Autism Provider list](#).
- Contact Premera at microsoft@premera.com to receive a copy of the certification criteria or for an application for providers not currently on the approved list.

For the purpose of this benefit only, services of a certified provider will be covered even if the provider does not meet the plan's requirements for an eligible provider under the [rehabilitation](#) or [mental health and chemical dependency treatment](#) benefits.

Covered services

Services must be ordered by the dependent's treating physician to be covered. An approved certified provider acts as the program manager for the member. Benefits are available for time used to evaluate the member and document findings and progress reports, and to create and update treatment plans; and time used to train and evaluate the work of the therapy assistants working directly with the member to implement the treatment plan.

In most cases, therapy assistants will provide the implementation portion of the treatment plan. Therapy assistant time is eligible for face-to-face time with the member to perform the tasks described in the treatment plan and to document outcomes; and time to meet with the program manager for training and to discuss treatment plan issues. Therapy Assistant services that are provided by a Program Manager will be paid at the Therapy Assistant rate.

Claims for ABA services should clearly list the level of service (certified provider/program manager; or therapy assistant), the date the service was provided, the time the service started and ended, the hourly charge for the service, and the total charge for that service. Therapy Assistant services that are provided by a Program Manager will be paid at the Therapy Assistant rate.

ABA services are not covered for the following:

- Babysitting or doing household chores
- Time spent under the care of any other professional
- Travel time
- Home schooling in academics or other academic tutoring

Benefit coverage above the allowable charges

You may be billed for charges assessed above the allowable charges since these providers have not agreed to offer discounts to members covered by this plan. Any amounts you pay for charges in excess of allowable charges, will not count towards satisfying any deductible requirements, or out-of-pocket maximums that may apply to other benefits provided through this plan.



An **allowable charge** is the negotiated amount that providers have agreed to accept as payment in full for a covered service. Out-of-network providers may not accept the allowable charge as payment in full. You are responsible for paying the difference between the allowable charge and the amount your out-of-network provider charges.

Prior Authorization

Prior authorization, also referred to as a pre-service review, is recommended to determine coverage is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.



Prior authorization is an advance determination by Premera that the service is medically necessary and that the member's plan has benefits available for the service being requested. This determination is offered in certain situations where medical records must be provided to establish medical necessity before the plan will pay for the service. Services are subject to eligibility and benefits at the time of service.

Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition based on national, evidence-based guidelines. Premera and Microsoft reserve the right to have appropriate medical professionals review current treatment at any time to determine if eligibility criteria continue to be met.

For ABA/Autism benefits, the prior authorization requires the following documents:

- The dependent's treating physician order for ABA services
- The clinical documentation of the qualifying diagnosis
- The Plan of treatment created by the approved program manager

For the autism/ABA therapy benefit, Premera will issue a prior authorization on this service that will pertain to a six-month period of treatment. The prior authorization process and subsequent clinical review includes the following steps:

1. The dependent child's treating physician or specialist diagnoses the child with an Autism Spectrum Disorder (Autistic Disorder, Childhood Disintegrative Disorder, Rett's Disorder, Pervasive Developmental Disorder Not Otherwise Specified, or Asperger's Disorder) and refers the child for ABA treatment.
2. An initial evaluation is performed by the approved certified provider to determine if the child is a candidate for an ABA and/or related structured behavioral program. If the child is determined to be a candidate by the evaluating approved certified provider, the approved certified provider would create and submit a treatment plan including type and frequency of services planned for the immediate six-month period. The approved certified provider must send the treatment plan to Premera so that eligibility for services can be determined.
3. Every six months, the approved certified provider who is overseeing the treatment must submit an updated treatment plan to Premera. The approved certified provider must determine that the treatment plan and services being provided are in accordance with ABA guideline. If any substantial change in the frequency or

type of program is necessary during the six-month treatment time, a revised treatment plan checklist should be submitted to Premera for notification of the revision of the treatment plan.

4. Progress reports should be created at least monthly by the certified provider to include documentation of the therapy assistant interventions and/or his or her own interventions with the child and a written summary of the child's progress. If the child has not made progress in the last six months, the updated treatment plan checklist should reflect a change in approach. Progress reports should be available to Premera upon request.

Services for this treatment that do not meet criteria described in the program are subject to retrospective denial of benefits. Claims for these services must be accompanied by a completed Autism/ABA therapy services billing summary signed by the certified provider and the member's parent.

Additional exclusions and limitations for autism/ABA therapy

In addition to the plan's [Exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- This benefit is not provided for rehabilitation services (which apply under the [rehabilitation](#) benefit) or mental health services (which apply under the [mental health and chemical dependency](#) benefit).
- Benefits for services provided by volunteers, childcare providers, family members and benefits paid for by state, local and federal agencies will not be covered. Volunteer services or services provided by a family member of the child receiving the services by or through a school, books and other training aids will also not be covered.
- Other unspecified developmental disorders or delays, or any other delay or disorder in a child's motor, speech, cognitive, or social development are not covered under this benefit.
- This benefit covers only the allowable fees for eligible services performed by the approved certified provider and those providing interventions based on principles of ABA and/or related structured behavioral programs under the supervision of the approved certified provider. Other expenses associated with providing the treatment, such as the tuition, program fees, travel, meals, and lodging of the approved certified provider, expenses of those working under the approved certified provider's supervision, the dependent, and his or her family members will not be covered.

Chiropractic services, acupuncture, and medical massage therapy

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

Limit: up to 24 visits per member per calendar year chiropractic, acupuncture, and medical massage therapy (combined)

This benefit covers (1) chiropractic services from a licensed chiropractor, (2) acupuncture services provided when medically necessary to relieve pain or to treat a covered illness, injury, or condition received from licensed acupuncturist or a provider licensed to perform acupuncture, and (3) medical massage therapy with a physician's prescription received from a licensed massage therapist. To be covered, these services must be rendered to restore or improve a previously normal physical function and delivered within the provider's scope of practice guidelines.

These covered services must be [medically necessary](#) and will be covered only when the provider is providing the service within the scope of his or her state license.

These covered services (chiropractic services, acupuncture, medical massage therapy) provided will accrue toward the 24-visit annual maximum. For example, if you visit a chiropractor for covered services 20 times in a

calendar year, you have four visits available for covered medical massage or acupuncture services in that calendar year.

Contraception

In-network: 100%

Out-of-network: 100%

This benefit covers contraceptive devices and injections for contraceptive purposes when prescribed by a physician. Included are diaphragms, IUDs, and Depo Provera injections. Removal of contraceptive devices by a physician is also covered.

All single-source brand and generic birth control medications are covered under the [preventive care](#) benefit at 100%.

Cosmetic and reconstructive surgery

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers services, supplies, and procedures for cosmetic, plastic, or reconstructive surgery purposes, along with complications of these services, supplies, or procedures for the following:

- Repair of a defect that is the direct result of an accidental injury, providing such repair is started within 12 months of the date of the accident
- Treatment for a congenital anomaly of a child
- Treatment of visible birth marks of a covered child
- Reconstruction of the involved breast following a mastectomy. Benefits are also provided for the reduction of the non-diseased breast to make it equal in size to the diseased breast after definitive reconstructive surgery on the diseased breast has been performed. No other cosmetic breast surgery is covered.
- Correction of physical functional disorders. Benefits may include, but are not limited to, blepharoplasty or breast reduction.

The treatment plan for any of the above conditions must be prescribed by a physician.



A **congenital anomaly** is a marked difference from the normal structure of a body part that is physically evident from birth.

A **physical functional disorder** is a limitation from normal (or baseline level) of physical functioning that may include, but is not limited to, problems with ambulation, mobilization, communication, respiration, eating, swallowing, vision, facial expression, skin integrity, distortion of nearby body parts or obstruction of an orifice. The physical functional impairment can be due to structure, congenital deformity, pain, or other causes. Physical functional impairment excludes social, emotional and psychological impairment or potential impairment.

Dental services

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers certain services from a dental provider that would otherwise be covered by this plan if performed by a physician, as long as these services are provided within the scope of the dental provider's license.



Review the [Dental plan](#) section for information on your dental benefits.

Covered services

This benefit covers treatment of a fractured jaw, excision of a tumor or cyst of the mouth, and incision or drainage of an abscess or cyst of the mouth.

Facility fees and/or anesthesia fees for treating dental conditions are eligible for payment under the medical benefit if any of the following criteria are met:

- The member has a medical condition his or her physician determines would place the member at undue risk if the dental procedures were performed in a dental office, or general anesthesia or IV sedation is required
- The member has a physical or mental handicap and cannot be managed with local anesthesia
- The member is a child who after other means of patient management have been tried, cannot be treated in the office setting
- The member is a child for whom other means of patient management are contraindicated

Orthodontia services may be eligible for payment under the medical plan for dependents born with cleft/lip palate or other severe craniofacial anomalies. To qualify for benefits the condition must meet medically necessary criteria in Premera's medical policy addressing orthodontia for repair of cleft palate and other severe congenital anomalies.

Prior Authorization

Prior authorization, also referred to as a pre-service review, is recommended to determine coverage is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.



Prior authorization is an advance determination by Premera that the service is medically necessary and that the member's plan has benefits available for the service being requested. This determination is offered in certain situations where medical records must be provided to establish medical necessity before the plan will pay for the service. Services are subject to eligibility and benefits at the time of service.

Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition based on national, evidence-based guidelines. Premera and Microsoft reserve the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

Additional exclusions and limitations for dental services

In addition to the plan's [Exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- Services or supplies not medically necessary for diagnosis, care, or treatment of a disease, illness, or injury
- Dental care and services of a dentist, except as provided in the dental benefit. Hospital and physician services in support of all other dental care are covered only if the care meets two conditions: (1) adequate dental treatment cannot be rendered without the use of the hospital, and (2) the member has a health problem that makes it medically necessary to do the dental work at the hospital.
- Dental services for accidental injuries to the oral and maxillofacial region are covered only when the needed corrective dental repairs are certified in writing by the dental care provider as dentally necessary and are directly related to the accidental injury. Covered dental services include the repair or replacement of existing crowns, inlays, onlays, bridgework, and dentures. The treatment must be started within one year from the date of the accident.
- Benefits for services or supplies for treatment of temporomandibular joint (TMJ) dysfunction or myofascial pain dysfunction (MPD); benefits may be available under the Microsoft temporomandibular dysfunction benefit
- The medical plan does not cover any other preventive or restorative dental procedures, regardless of origin of condition

Diabetes health education

In-network: 100%

Out-of-network: 100% of allowable charges

This benefit covers outpatient self-management training and education for diabetes, including medical nutritional therapy by a dietician or nutritionist with expertise in diabetes.

Emergency room care and professional services

In-network: 90%, deductible applies

Out-of-network: 90%, deductible applies

This benefit covers hospital emergency room and provider charges—regardless of the network status—including related services and supplies, such as diagnostic imaging (including X-ray) and laboratory services, and surgical dressings and drugs furnished by and used while at the hospital.

Following discharge from the emergency room or hospital, eligible services will be paid based on the contracting status of the provider.

Regardless of network status, after being treated in the emergency department for an emergent condition and admitted to a hospital inpatient care (as defined by the [hospital inpatient care](#) benefit), along with provider charges, will be covered at the in-network level.

For emergency substance abuse treatment, see the [mental health and chemical dependency treatment](#) benefit.

Hearing care and hardware

Hearing exams and testing

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers one routine hearing examination and one routine hearing test (or screening) per member each calendar year.

Hearing exam services include:

- Examination of the inner ear and exterior of the ear
- Observation and evaluation of hearing, such as whispered voice and tuning fork
- Case history and recommendations
- The use of calibrated equipment

Hearing hardware

In-network: 90%, deductible applies

Out-of-network: 90%, deductible applies

Limit: up to \$3,000 maximum every three years per member

This benefit covers hearing hardware up to a maximum benefit of \$3,000 per member in a period of three consecutive calendar years.

Before obtaining a hearing aid, you must be examined by a licensed physician (M.D. or D.O.) or audiologist (CCC-A or CCC-MSPA).

Benefits cover the following:

- The hearing aid(s) (monaural or binaural) prescribed as a result of an exam
- Ear mold(s)
- Hearing aid rental while the primary unit is being repaired
- The initial batteries, cords, and other necessary ancillary equipment
- A follow-up consultation within 30 days following delivery of the hearing aid with either the prescribing physician or audiologist
- Repairs, servicing, and alteration of hearing aid equipment

Additional exclusions and limitations for hearing care and hardware

In addition to the plan's [Exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- Hearing aids purchased before your effective date of coverage under this plan
- A hearing aid, for any reason, more often than once in a period of three consecutive calendar years
- Batteries or other ancillary equipment other than that obtained upon purchase of the hearing aid
- A hearing aid that exceeds the specifications prescribed for correction of hearing loss
- Expenses incurred after your coverage ends under this plan unless a hearing aid was ordered before that date and was delivered within 90 days after the date your coverage ended
- Charges in excess of this benefit; these expenses are also not eligible for coverage under other benefits of this plan

Home health care

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers visits for intermittent care by a registered nurse (RN) or licensed practical nurse (LPN), a licensed physical or occupational therapist, a certified speech therapist, social worker (MSW) working for home health agency, or a certified respiratory therapist. The benefit includes the cost of a home health aide when

acting under the direct supervision of one of the before-mentioned therapists and while performing services specifically ordered by the doctor in the treatment plan. The benefit also includes disposable medical supplies and eligible medication prescribed by a physician when provided by the home health care agency.



Intermittent care is care provided due to the medically predictable recurring need for skilled home health care services.

Home health care services provided and billed by a Medicare-approved or state-licensed home health care agency for treatment of an illness or injury are covered. The services must be part of a formal written treatment plan prescribed by your doctor.

One postpartum home health visit within 30 days of the discharge of the baby from the hospital or alternative birthing center will be eligible for coverage.

Additional exclusions and limitations for home health care

In addition to the plan's [Exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- Normal living expenses, such as food, clothing, and household supplies; housekeeping services, except for those of a home health aide as prescribed by the plan of care; and transportation services
- Materials such as handrails and ramps
- Services performed by family members and volunteer workers
- Psychiatric care
- Unnecessary and inappropriate services
- Maintenance or [custodial care](#)
- Diversional therapy
- Services or supplies not included in the written treatment plan
- Over-the-counter drugs, solutions, and nutritional supplements
- Dietary assistance, such as Meals on Wheels
- Services provided to someone other than the ill or injured enrollee

Hospice care

In-network: 90%, deductible applies

Out-of-network: 90%, deductible applies

The hospice care benefit allows a terminally ill member to remain at home or to use the services of a hospice center instead of using hospital inpatient services. The plan covers services provided through a state-licensed hospice or other hospice program that meets the standards of the National Hospice Organization. The services must be part of a written treatment plan prescribed by a licensed physician.

This benefit covers visits for intermittent care by a registered nurse (RN) or licensed practical nurse (LPN), a licensed physical or occupational therapist, a certified speech therapist, a certified respiratory therapist or a master of social work. Also included is the cost of a home health aide who acts under the direct supervision of one of the before-mentioned therapists and who is performing services specifically ordered by the member's doctor in the treatment plan. The benefit also includes disposable medical supplies and medications prescribed by the physician, and the rental of durable medical equipment.

In addition, the hospice care benefit covers care in a hospice, and up to 240 hours of respite care for each six-month period of hospice care. The respite care provision allows family members of the terminally ill patient an opportunity to recover from the emotionally and physically demanding tasks of caring for the patient.



Hospice care is a coordinated program of palliative and supportive care for dying members by an interdisciplinary team of professionals and volunteers centering primarily in the member's home.

Intermittent care is care provided due to the medically predictable recurring need for skilled home health care services.

Respite care is continuing to provide care in the temporary absence of the member's primary caregiver or caregivers.

Additional exclusions and limitations for hospice care

In addition to the plan's [Exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- Bereavement or pastoral counseling
- Financial or legal counseling, including real-estate planning or drafting of a will
- Funeral arrangements
- Diversional therapy
- Services that are not related solely to the member, such as transportation, house cleaning, or sitter services

Hospital inpatient care

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers the following inpatient medical and surgical services:

- Room and board, including general duty nursing and special diets
- Use of an intensive care or coronary care unit equipped and operated according to generally recognized hospital standards
- Operating room, surgical supplies, hospital anesthesia services and supplies, drugs, dressings, equipment, and oxygen
- Diagnostic and therapeutic services
- Blood, blood derivatives, and their administration

Regardless of network status, after being treated in the emergency department for an emergent condition and admitted to a hospital inpatient care (as defined by the hospital inpatient care benefit), along with provider charges, will be covered at the in-network level.

For inpatient hospital substance abuse treatment, see the [mental health and chemical dependency treatment](#) benefit.

Additional exclusions and limitations for hospital inpatient care

In addition to the plan's [Exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- Hospital admissions for diagnostic purposes only, unless the services cannot be provided without the use of inpatient hospital facilities, or unless the member's medical condition makes inpatient care medically necessary

- Any days of inpatient care that exceed the length of stay required to treat the member's condition

Hospital outpatient care and ambulatory surgical center care

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers operating, procedure, and recovery rooms; plus services and supplies, such as diagnostic imaging (including X-ray) and laboratory services, X-ray and radium therapy, anesthesia and its administration, surgical dressings and drugs, furnished by and used while at the hospital or ambulatory surgical center.

Infertility

In-network: 90%, deductible applies

Out-of-network: 90% of allowable charges, deductible applies

Limit: up to \$15,000 lifetime benefit maximum per member

This benefit covers services to assist in achieving a pregnancy for Microsoft employees and their enrolled spouse/domestic partner regardless of reason or origin or condition. Covered services include but are not limited to:

- Intrauterine insemination (also known as artificial insemination)
- In vitro fertilization (IVF)
- Gamete intra-fallopian transplant (GIFT)
- Intracytoplasmic sperm injection (ICSI)
- Pre-implantation genetic diagnosis (PGD)
- Services used to preserve fertility such as cryopreservation of eggs, sperm and/or embryos due to infertility or likelihood of future infertility caused by a medical condition that poses a risk to fertility (examples include, but are not limited to: chemotherapy, chronic disease, specific medications, autoimmune issues that impact ovarian function, loss of an ovary or surgery to both ovaries).

Drugs prescribed as part of infertility treatment can be purchased from any retail pharmacy (including an Express Scripts Pharmacy) or the Express Scripts Pharmacy by mail home delivery program.

Lifetime benefit maximum

This benefit provides coverage up to a \$15,000 lifetime maximum per member. Drugs used to treat infertility are subject to this benefit's lifetime maximum.

If only one member is involved in the treatment, the cost of the services will count only toward that member's benefit lifetime maximum.

Example

Gerardo and his wife Elyse are trying to conceive. Elyse gets a test of her hormone levels. This test would count toward Elyse's infertility lifetime benefit maximum. A sperm penetration study would count toward Gerardo's infertility lifetime benefit maximum.

Any eligible service, procedure or test performed, drug, or supply that cannot be assigned specifically to either of the participants by using the criteria described above will be assigned to the lifetime benefit maximum of the member whose name appears on the claim submitted for those services.

Additional exclusions and limitations for infertility

In addition to the plan's [Exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- Fees paid to donors for their participation in any service
- Testing and treatment for potential surrogates is not covered other than testing and treatment that would be eligible if provided to a member
- Assisted fertility services, procedures, drugs, or supplies determined to be experimental or investigative
- Any services used to preserve the possibility of fertility except when medical conditions are present that pose particular risk to fertility as noted above

Lab tests

In-network: 90%, deductible applies

Out-of-network: 90% of allowable charges, deductible applies

This benefit covers diagnostic lab tests, including the administration and interpretation, when ordered by a licensed physician.



A pre-service review is recommended for **Genetic Testing** to determine if coverage is available before the service occurs. Either the member or the provider may contact Premera for a pre-service review.

Maternity care (other than Preventive Care)

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers maternity benefits provided for you, your enrolled spouse/domestic partner, and your eligible dependent children. Benefits are for maternity care in a hospital, alternative birthing center, or at home, including:

- Prenatal testing when required to diagnose conditions of the unborn child
- Routine prenatal professional office visits (if physician bills the delivery with prenatal care then 40% of allowed amount will be covered under the preventive benefit)
- Services of a licensed nurse or midwife
- Miscarriages and terminations of pregnancy
- Hospital nursery care for benefits-eligible infant while the mother is hospitalized and receiving benefits; services are covered under the hospital services benefit
- Male circumcision by a physician or mohel for a benefits-eligible dependent; services are covered under the physician services benefit
- One postpartum home health visit within 30 days of the discharge of the baby from the hospital or alternative birthing center
- Home births include an allowance of up to \$500 for eligible supplies and/or equipment used for home delivery; for example, birthing packs, birthing tubs, monitoring devices, local anesthetics, and comfort aids. Services for the newborn including hospital services and professional services are covered under the hospital services and physician services benefit.

Prenatal care:

In-network: 100%/40%/60%, deductible applies to non-preventive

Out-of-network: 70%/40%/60% of allowable charges, deductible applies to non-preventive

- Routine prenatal office visits are covered as preventive. If the physician bills one charge which includes the routine prenatal office visits and the delivery (i.e. normal deliveries and cesarean sections) then 40% of the allowed amount for this total charge will be covered as preventive. The remaining 60% of the allowed amount will be subject to the deductible and coinsurance.

The [home health care](#) benefit covers one postpartum health visit within 30 days of the discharge of the baby from the hospital or alternative birthing center.

Medical equipment and supplies (durable medical supplies)

In-network: 90%, deductible applies

Out-of-network: 90% of allowable charges, deductible applies

Covered services

This benefit covers charges for durable medical and surgical equipment and supplies, (DME). Benefits cover rental or purchase (including shipping and handling fees) of DME for treatment of an injury, illness, disease, or medical condition. Rental equipment will not be reimbursed above the purchase price of the equipment.

Allowed charges to repair or replace covered items are also covered due to a change in the injury, illness, disease, or medical condition, the growth of a child, or when worn out by normal use. Replacement is covered only if needed due to a change in the member's physical condition or if it is less costly to replace than to repair existing equipment or to rent similar equipment.

In order to be covered, DME must be no more than one item of equipment for the same or similar purpose regardless if the plan covered the initial item or not, and the equipment and accessories to operate it must be:

- Made to withstand prolonged use
- Made for and mainly used in the treatment of an injury, illness, disease, or medical condition
- Suited for use in the home

This list of covered DME includes, but is not limited to:

- Braces
- Crutches
- Wheelchairs
- Prostheses
- Foot orthotics (custom fitted shoe inserts) and therapeutic shoes (orthopedic), including fitting expenses, when prescribed by a physician for the condition of diabetes or for corrective purposes
- Wigs (up to \$300 per calendar year for alopecia caused by medical conditions or treatment for diseases)
- Over-the-counter breast pumps intended for use in the home (covered at 100% of allowable charges; deductible does not apply; hospital grade breast pumps are not covered except when used in an inpatient setting)
- Continuous glucose monitors and their supplies will be covered at 100% of allowable charges; deductible does not apply for members with Type 1 Diabetes who are age 25 and over. For those under 25 medical review will be required.

Vision hardware may be covered under the medical plan for certain medical conditions of the eye, including, but not limited to:

- Corneal ulcer/abrasion
- Bullous keratopathy
- Recurrent erosion of cornea
- Keratoconus
- Tear film insufficiency (dry-eye syndrome)
- Cataract surgery



Certain supplies such as hypodermic needles, test strips and glucose monitors are covered at 100% by the preventive care benefit.

Additional exclusions and limitations for durable medical and surgical equipment and supplies

In addition to the plan's Exclusions and limitations, the following durable medical equipment and supplies will not be covered by this plan when they are:

- Normally of use to persons who do not have an injury, illness, disease, or medical condition
- For use in altering air quality or temperature
- For exercise, training and use during participation in sports, recreation, or similar activities
- Equipment, such as whirlpools, portable whirlpool pumps, sauna baths, massage devices, overbed tables, elevators, vision aids, and telephone alert systems
- Equipment or supplies used for treatment of erectile dysfunction
- Special or extra-cost convenience features
- Structural modifications to your home and/or private vehicle
- Replacement of lost or stolen equipment or supplies

Mental health and Chemical Dependency

Inpatient and Outpatient:

- 100%, up to calendar year visit limits through Microsoft CARES employee assistance program, then
- In-network: 90%, deductible applies
- Out-of-network: 70% of allowable charges, deductible applies

This benefit covers medically necessary treatment for:

- mental health such as, but not limited to the diagnosis and treatment of psychiatric disorders, eating disorders, attention deficit disorder (ADD), attention deficit hyperactivity disorder (ADHD)
- chemical dependency such as substance abuse and alcoholism

To be covered, services must be furnished by an eligible provider.

All mental health and chemical dependency treatment must be medically necessary to be eligible for coverage. Prior authorization is recommended for inpatient care, eligible residential treatment centers, partial hospitalization programs, and intensive outpatient program services. When an emergency admission occurs notification to Premiera within two days is also recommended.

Type of care	You will be covered as follows
Through the Microsoft CARES employee assistance program (EAP) as administered by Wellspring Family Services	<ul style="list-style-type: none"> No deductible applies 100% of eligible charges up to calendar year visit limits <ul style="list-style-type: none"> Three visits per member for individual counseling Three telephonic counseling sessions per member for individual counseling Eight visits per family for family or married/domestic partner couples counseling <p>A visit includes each attendance of the provider to the member, regardless of the type of professional services rendered, and whether it might otherwise be termed consultation, treatment, or described in some other manner. For benefit calculation purposes, a typical mental health visit is considered one hour.</p>
Inpatient and Outpatient benefits	<ul style="list-style-type: none"> In-network: 90%, deductible applies; out-of-network: 70% of allowable charges, deductible applies

Eligible providers

Eligible providers include:

- A facility licensed as a hospital or community mental health agency to provide mental health and/or substance abuse services
- A physician, psychiatrist, psychologist, or psychiatric nurse practitioner licensed to provide mental health or substance abuse services
- A master's level mental health provider licensed, registered, or certified as legally required to provide mental health services
- Any other provider or facility who is licensed or certified by the state in which the care is rendered and who is providing care within the scope of their license or certification

Prior Authorization

A prior authorization, also referred to as a pre-service review, is recommended to determine coverage is available before the service occurs. Either the member or the provider may contact Premera for a prior authorization.



A **prior authorization** is an advance determination by Premera that the service is medically necessary and that the member's plan has benefits available for the service being requested. This determination is offered in certain situations where medical records must be provided to establish medical necessity before the plan will pay for the service. Services are subject to eligibility and benefits at the time of service.

The prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition, based on national, evidence-based guidelines. Premera and Microsoft reserve the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

Additional exclusions and limitations for mental health and chemical dependency

In addition to the plan's Exclusions and limitations, the following exclusions and limitations apply to this benefit:

- Testing must be ordered by a physician for the purpose of diagnosing or medical management
- Smoking cessation programs or materials; (Microsoft provides a separate Smoking Cessation Program. Prescription drugs for smoking cessation are covered under the prescription drug benefit.)
- Services and supplies that are court-ordered, or are related to deferred prosecution, deferred or suspended sentencing, or driving rights, if those services are not deemed medically necessary
- Educational or recreational therapy or programs; this includes, but is not limited to boarding schools and wilderness programs. Benefits may be provided for medically necessary treatment received in these locations if treatment is provided by an eligible provider.

Mobile medicine program

In-network: 90%, deductible applies

Out-of-network: Not applicable

Coverage available in the Puget Sound area only

This benefit covers medical treatment, in-network, via the phone, webcam, or home visit for members who experience an illness or injury that requires urgent, but not life-threatening medical attention when provided by Carena. To be eligible for the program, members must be located in the Puget Sound service area.

Carena-contracted medical providers include board-certified physicians and nurse practitioners who specialize primarily in family or emergency room medicine. When appropriate, these providers will assess and treat conditions via the phone, webcam, or home visit, including providing information about the condition that requires treatment and other conditions that may be affected by the current concern.



Access this program by calling the 24-Hour Nurse Line at (800) 676-1411.

If the Nurse Line nurse's assessment is that your health issue is urgent, but not life-threatening, and that you should receive care from a provider within four to six hours, you can be referred to the Microsoft Mobile Medicine program. A Carena provider will then determine the most appropriate treatment for your concern.



Phone and webcam visits are available 24 hours a day, seven days a week; house calls are available from 6 A.M. through midnight, seven days a week.

To maintain continuity of care, a medical record of care regarding the assessment and treatment provided by Carena, will be forwarded to the member's primary care provider. If the member has not yet established a primary care provider, the Carena provider can assist in identifying in-network providers in the area for the member's follow-up care. Carena providers do not have private practices and are not available for follow-up care. After a Carena visit is completed, subsequent care will be subject to the appropriate level of benefits.

Nursing care

In-network: 90%, deductible applies

Out-of-network: 90%, deductible applies

This benefit covers skilled care by a registered nurse (RN) or licensed practical nurse (LPN) ordered by a physician. Coverage is for private duty nursing and not nursing that is provided by a home health agency. The nurse who is providing the care cannot be a permanent resident in the member's home.



Skilled nursing care is provided by a registered nurse (RN) or licensed practical nurse (LPN) and the care must require the technical proficiency, scientific skills, and knowledge of an RN or LPN. The need for skilled nursing is determined by the condition of the patient, the nature of the services required, and the complexity or technical aspects of the services provided. Nursing care is not skilled simply because an RN or LPN delivers it or because a physician orders it.

Nutritional therapy

In-network: 100%

Out-of-network: 100% of allowable charges

Limit: first 12 visits per member per calendar year

Additional visits above the 12

In-network: 90%, deductible applies

Out-of-network 70% of allowable, deductible applies

This benefit covers consultation with a dietician or nutritional therapist or certified lactation consultant for a chronic illness or condition that is impacted by diet and when recommended by in the member's physician. The calendar year visit limit is waived and benefits will continue to pay at the same rate for visits over 12 for nutritional therapy received in connection with a diagnosed eating disorder or diabetes.

Illnesses or conditions that would be eligible for this benefit include, but are not limited to:

- Hypertension
- Cardiac problems
- Failure to thrive
- Gastric reflux disease

Physician services

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers:

- Medical and surgical services of a physician
- Urgent care visits at an urgent care facility
- Care via online and telephonic methods when medically appropriate:
 - Benefits for telehealth are subject to standard office visit cost-shares and other provisions as stated in this booklet. Services must be medically necessary to treat a covered illness, injury or condition.
- Biofeedback services for any condition covered by the medical benefit when provided by an eligible provider
- Routine foot care when the enrollee is a diabetic
- One initial visit for evaluation of condition otherwise excluded by the contract (for example, sexual dysfunction) to exclude medical conditions that could be an underlying cause



An **Urgent care** visit is billed and covered at the same rate as an office visit with your regular physician and is a cost-effective option when you have an urgent need for care. Urgent care is the best option for treatment of a sudden illness, injury or condition that:

- Requires prompt medical attention to avoid serious deterioration of the member's health
- Does not require the level of care provided in the emergency room or a hospital
- Cannot be postponed until the member's physician is available

A **Physician** is a state-licensed:

- Doctor of Medicine and Surgery (M.D.)
- Doctor of Osteopathy (D.O.)

In addition, professional services provided by one of the following types of providers will be treated as physician services under this plan to the extent the provider is providing a service that is within the scope of his or her state license and providing a service for which benefits are specified in this plan and would be payable if the service were provided by a physician as defined above:

- Chiropractor (D.C.)
- Dentist (D.D.S. or D.M.D.)
- Optometrist (O.D.)
- Podiatrist (D.P.M.)
- Psychologist (Ph.D.)
- Advanced Registered Nurse Practitioner (A.R.N.P.)
- Nurse (R.N.)
- Naturopathic physician (N.D.)

Prescription drugs

In-network: 90%, deductible applies, up to limits provided below

Out-of-network: 90%, deductible applies, up to limits provided below

This benefit covers most FDA-approved, medically necessary prescription drugs, when prescribed for the member's use outside of a medical facility and dispensed by a licensed pharmacist in a pharmacy licensed by the state in which the pharmacy is located. Also included in this benefit are injectable supplies.

Certain single-source brand and generic preventive drugs will be covered at 100% under the preventive care benefit and are not subject to the deductible. Brand-name preventive medications with a generic equivalent will not be covered by the preventive care benefit. Review the [preventive care](#) benefit for more information.

Charges for [infertility drugs](#) over and above the infertility lifetime benefit maximum do not apply to your deductible or coinsurance maximum.



A **prescription drug** is any medical substance that cannot be dispensed without a prescription according to federal law. Only medically necessary prescription drugs are covered by this plan.

Brand-name prescriptions are sold under a trademark name. An equivalent generic drug may or may not be available at lower cost, depending upon whether the patent on the brand-name drug has expired.

Generic drugs are equivalent to brand-name drugs but available at a lower cost than brand-name prescriptions because the patent has expired.

Prescription limits

	Retail pharmacy	Home delivery	Specialty pharmacy
Coverage	<ul style="list-style-type: none"> Up to a 90-day supply for generic maintenance medication; all others are up to a 30-day supply* 	<ul style="list-style-type: none"> Up to 90-day supply* 	<ul style="list-style-type: none"> Up to a 30-day supply* Additional clinical support for members using specialty drugs
In-network pharmacies	<ul style="list-style-type: none"> Express scripts pharmacies bill the plan on your behalf To find an Express Scripts retail pharmacy, call the Premera customer service team at (800) 676-1411 	<ul style="list-style-type: none"> Express scripts pharmacies bill the plan on your behalf 	<ul style="list-style-type: none"> Walgreens or Accredo specialty pharmacies bill the plan on your behalf
Out-of-network pharmacies	<ul style="list-style-type: none"> You will need to submit a prescription reimbursement form, with your receipt, for reimbursement 	<ul style="list-style-type: none"> You will need to submit a prescription reimbursement form, with your receipt, for reimbursement 	<ul style="list-style-type: none"> You will need to submit a prescription reimbursement form, with your receipt, for reimbursement

* Unless the drug maker's packaging limits the supply in some other way.



Generic maintenance medications have a common indication for the treatment of a chronic disease (such as diabetes, high cholesterol, or hypertension). Indications are obtained from the product labeling. They are used for diseases when the duration of the therapy can reasonably be expected to exceed one year.

Specialty drugs are high-cost drugs, often self-injected and used to treat complex or rare conditions, including rheumatoid arthritis, multiple sclerosis, and hepatitis C. Specialty drugs may also require special handling or delivery. These medications can be dispensed only for up to a 30-day supply.



Premera provides a customer service team dedicated to Microsoft employees and their dependents. You can use this service by calling (800) 676-1411 with questions regarding:

- Status of mail order prescriptions
- Plan design, including which medications are covered or not covered
- Location of retail pharmacies

Covered drugs

This benefit covers the following FDA-approved items when dispensed by a licensed pharmacy for use outside of a medical facility. Certain drugs may need a prior authorization.

- Prescription drugs (Federal Legend and State Restricted Drugs as prescribed by a licensed provider). This benefit includes coverage for off-label use of FDA-approved drugs as provided under this plan's definition of prescription drug.
- Compounded medications of which at least one ingredient is a covered prescription drug subject to standard supply limit
- Inhalation spacer devices and peak flow meters
- Glucagon and allergy emergency kits
- Prescribed injectable medications for self-administration (such as insulin)
- Hypodermic needles, syringes, and alcohol swabs used for self-administered injectable prescription medications

- Disposable diabetic testing supplies, including test strips, testing agents, and lancets
- Prescription contraceptive drugs and devices (for example, oral drugs, diaphragms, and cervical caps)
- Infertility drugs; these drugs are covered at the benefit percentages listed for the [infertility](#) benefit and are subject to the infertility lifetime benefit maximum
- Human growth hormone
- Prescription drugs for smoking cessation

Benefits for immunization agents and vaccines, including the professional services to administer the medication, are provided under the [preventive care](#) benefit.

Prior Authorization

Prior authorization, also referred to as a pre-service review, is recommended to determine coverage is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.



Prior authorization is an advance determination by Premera that the service is medically necessary and that the member's plan has benefits available for the service being requested. This determination is offered in certain situations where medical records must be provided to establish medical necessity before the plan will pay for the service. Services are subject to eligibility and benefits at the time of service.

Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition based on national, evidence-based guidelines. Premera and Microsoft reserve the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

In order for certain types of drugs to be covered, information from your doctor must be submitted that identifies the disease being treated and explains the role of the drug in the treatment plan to establish its medical necessity. If that information is made available prior to the prescription being filled, and it is determined that the drug is medically necessary, the prescription will be covered as described above. If information for a drug in this category is not provided, you may pay for the prescription to be filled and submit the claim for consideration along with the clinical information. If it is determined that you do not meet medical necessity criteria needed for the drug to be eligible, you will not be reimbursed for the cost of the drug.

Benefits for some prescription drugs may be limited to one or more of the following:

- A set number of days' supply
- A specific drug or drug dose that is appropriate for a normal course of treatment
- A specific diagnosis
- Be under the care of an appropriate medical specialist
- Trying a generic drug or a specified brand name drug first

In making these determinations, Premera takes into consideration clinically evidence-based medical necessity criteria, recommendations of the manufacturer, the circumstances of the individual case, U.S. Food and Drug Administration guidelines, published medical literature and standard reference compendia.



For questions about your pharmacy benefits or quantity limits, please contact Premera Customer Service at (800) 676-1411.

The table below provides information on how to submit information for a medical necessity review.

Drug	Information
Impotence medication resulting from a secondary condition	Send clinical information about condition being treated to Express Scripts Home Delivery by mail with the prescription for the drug. If covered, supplies are limited to a maximum of 45 pills every 90 days.
Certain drugs require a review. Examples include: rheumatoid arthritis, certain cancer treatment drugs, growth hormones, anti-depressants, corticosteroid nasal sprays, diabetes, migraine therapy, multiple sclerosis and compound medications.	Have your provider call (888) 261-1756 to start or update the benefit review process for these or other drugs needing clinical review. If you would like to find out if your drug requires review call Premera Customer Services at (800) 676-1411.



Categories of drugs on this list may be added or deleted from time to time, based on factors including FDA approval status, medical necessity, member safety, and best practices. If you have paid for a prescription of a drug in this category, you may appeal any denial of benefits for that drug through the appeals process.

Drug-usage patterns

The plan may be provided with information from a variety of sources regarding drug-usage patterns of individual members that merit further investigation. If the conclusion of the investigation is that the drug-usage patterns are not consistent with generally accepted standards of practice, the plan may choose to restrict access to the benefit to one prescribing physician for those members. If this action is taken, the member will be notified in advance.

Your right to safe and effective pharmacy services

State and federal laws establish standards to assure safe and effective pharmacy services, and to guarantee your right to know what drugs are covered under this plan and what coverage limitations are in your contract.



If you want more information about the drug coverage policies under this plan, or if you have a question or a concern about your pharmacy benefit, call the Premera customer service team at (800) 676-1411.

If you have a concern about the pharmacists or pharmacies serving you, call your State Department of Health.

Additional exclusions and limitations for prescription drugs

In addition to the plan's [Exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- Drugs and medications not approved by the Food and Drug Administration (FDA) except as defined in the Experimental and Investigational section

- Drugs and medicines that may be lawfully obtained over the counter (OTC) without a prescription. OTC drugs are excluded even if prescribed by a practitioner, unless otherwise stated in this benefit. These may include, but are not limited to: nonprescription drugs and vitamins, food and dietary supplements, herbal or naturopathic medicines, and nutritional and dietary supplements (for example, infant formulas or protein supplements). This exclusion does not apply to emergency contraceptive methods (such as "Plan B"), aspirin for men and women, folic acid for women and iron supplements.
- Over-the-counter female contraceptive methods and supplies (for example, jellies, creams, foams, female condoms or devices) without a prescription even if used in conjunction with covered equipment or supplies, and all male contraceptives
- Drugs for the purpose of cosmetic use (for example, promote or stimulate hair growth, stop hair loss, or prevent wrinkles)
- Growth hormone for the diagnosis of idiopathic short stature (ISS), familial short stature (FSS), or constitutional short stature (CSS)
- Drugs for experimental or investigative use
- Any prescription refilled too soon or in excess of the number of refills specified by the prescribing provider, or any refill dispensed after one year from the prescribing provider's original order
- Replacement of lost or stolen medication
- Drugs to treat infertility are subject to limits and maximums of that benefit
- Drugs used for impotence except as listed under the Covered Drugs In Need of Clinical Information from your Doctor for Medical Necessity Review section
- Devices and appliances, support garments, and non-medical supplies
- Drugs used for weight loss or weight management
- This plan does not cover the cost of drugs that are reimbursed under another plan or another portion of your Microsoft coverage (for example, drugs administered while hospitalized)
- Charges for prescription drugs when obtained through an unauthorized pharmacy or provider when a restriction of the prescription drug benefit is in place

Preventive care

Preventive services:

- *In-network: 100%*
- *Out-of-network: 100% of allowable charges*

Preventive prescription drugs:

- *In-network: 100%*
- *Out-of-network: 100%*

This benefit covers routine exams, immunizations and health screenings, such as:

- Routine physicals for men and women
- Woman's preventive care including a gynecological exam, routine pap smear and routine mammogram
- Well-child exams, including physical exams, tests, and immunizations, through age 18
- Hearing screening for children through age 18
- Routine prenatal professional office visits (if the physician bills the delivery with the prenatal care then 40% of the allowed amount will be covered as preventive).
- Routine eye exams

- Flu shots
- Cancer screenings
- Immunizations, which need not be done at the same time as the routine exam

Prenatal care:

In-network: 100%/40%/60%, deductible applies to non-preventive

Out-of-network: 70%/40%/60% of allowable charges, deductible applies to non-preventive

- Routine prenatal office visits are covered as preventive. If the physician bills one charge which includes the routine prenatal office visits and the delivery (i.e. normal deliveries and cesarean sections) then 40% of the allowed amount for this total charge will be covered as preventive. The remaining 60% of the allowed amount will be subject to the deductible and coinsurance as stated in the [maternity care](#) benefit.

For individuals with known risk factors, such as family history of a disease with known hereditary links, the limits in the recommended guidelines for preventive screenings may not be applicable.



For a complete list of what is considered preventive care and paid 100% by the plan, see the [Preventive Care Services list](#) and the [Preventive Drug list](#), or contact Premera Customer Service at (800) 676-1411.

For information on how to fill your prescription, see the [prescription drug](#) section.

This benefit covers single-source brand and generic prescriptions to prevent the onset of disease by a person who has risk factors for a particular condition, or those taken to prevent a recurrence of a disease. Covered preventive prescription drugs include drugs for the treatment of high cholesterol with cholesterol-lowering medications to prevent heart disease, or the treatment of recovered heart attack or stroke victims with ACE inhibitor medications to prevent a recurrence. This benefit also covers certain supplies such as hypodermic needles, test strips and glucose monitors.

Rehabilitation

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers physical therapy, functional occupational therapy, and speech therapy services to:

- Restore and improve a bodily or cognitive function that was previously normal but was lost after an accidental injury or illness
- Treat disorders or delays in the development of language, cognitive, or motor skills

Inpatient services are covered when services cannot be rendered in any other setting. Outpatient services are limited to a maximum of one hour of each specialty (physical therapy, occupational therapy and speech therapy) per day.

Physical therapy, functional occupational therapy, and speech therapy are covered when rendered by a physician or by a licensed or registered physical or occupational therapist or a certified speech therapist that is licensed or registered as required as such by the state in which he or she practices.

Services rendered by a massage therapist are not covered under the rehabilitation benefit. Please refer to the Chiropractic services, acupuncture, and medical massage therapy benefit for coverage.

Respite Care

In-network: 90%, deductible applies

Out-of-network: 90%, deductible applies

Limit: 240 hours per calendar year

Respite care is for covered members who need assistance with activities of daily living (ADLs) such as bathing and dressing due to a permanent or temporary disabling medical condition, such as a traumatic brain injury, advanced multiple sclerosis, and severe cerebral palsy, where the member needs assistance moving from one place to the other. This benefit covers 240 hours per calendar year in the member's residential home to provide family caregivers an opportunity to recover from the emotionally and physically demanding tasks of caring for the covered member who requires assistance with ADLs.

The respite care application form and a home assessment must be completed prior to accessing this benefit. After the home assessment, Premera will make a determination if the covered member needs assistance with ADLs related to a disabling medical condition and qualifies for respite care coverage, which may be approved for up to a 12-month period. The home assessment is covered under the [Home health care](#) benefit. For the respite care application and more information on this benefit, please call Premera Customer Service at (800) 676-1411.

Additional exclusions and limitations for respite care:

In addition to the plan's [Exclusions and Limitations](#), the following exclusions and limitations apply to this benefit:

- Respite care provided by a non-certified or non-licensed provider or agency
- Respite care provided by a family member or friend
- Travel expenses, mileage, supplies or any other personal needs of the provider of the respite care
- Instrumental ADLs – examples of instrumental ADLs that are not covered by this benefit include, but are not limited to: shopping, housework, managing finances and using the computer.

Skilled nursing facility

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

Limit: up to 120 days per member per calendar year

This benefit covers inpatient care in a Medicare-approved skilled nursing facility for up to 120 days in each calendar year. Services must be part of a formal written treatment plan prescribed by the doctor. **Custodial care is not included in this coverage.**



Custodial care is provided primarily for ongoing maintenance of a person's condition or to assist a person in meeting activities of daily living, and not for therapeutic value or requiring the constant attention of trained medical personnel. Review the [glossary](#) for a full definition.

Services and supplies eligible for reimbursement include:

- Room and board, meals, and general nursing care
- Services and supplies furnished and used while you are in the skilled nursing facility, such as:
 - The use of special treatment rooms
 - Routine lab exams

- Physical
- Occupational or speech therapy
- Respiratory and other gas therapy
- Drugs and biologicals (such as blood products and solutions)
- Gauze, cotton, fabrics, solutions, plaster, and other materials used in dressings and casts

Additional exclusions and limitations for skilled nursing facility

In addition to the plan's [Exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- Custodial care is not provided
- Care that is primarily for senile deterioration, mental deficiency, or retardation, or the treatment of substance abuse and alcoholism

Sterilization services

Elective Sterilization – Female

In-network: 100%

Out-of-network: 100% of allowable charges

This benefit covers elective, permanent sterilization procedures, such as tubal ligation. Reversals or attempted reversals of these procedures are not covered.

Elective Sterilization – Male

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers elective, permanent sterilization procedures, such as vasectomy. Reversals or attempted reversals of these procedures are not covered.

Surgical weight loss treatment

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers you, your spouse/domestic partner, or dependent when the criteria listed in the Premera Medical Policy on Bariatric Surgery are met.



Contact Premera at (800) 676-1411 for a copy of the policy.

Who is eligible

Examples of qualifying criteria include:

- A Body Mass Index (BMI) greater than 40 Kilograms (kg) per square meter (m2) or BMI greater than 35 Kg per m2 in conjunction with severe diabetes, hypertension, or obstructive sleep apnea
- Physician-supervised weight reduction program which includes:

- A program of at least six consecutive months in duration, within the two-year period prior to surgery being considered.
- Evidence of active participation in a program documented in the member's medical records

Prior Authorization

Prior authorization, also referred to as a pre-service review, is recommended to determine coverage is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.



Prior authorization is an advance determination by Premera that the service is medically necessary and that the member's plan has benefits available for the service being requested. This determination is offered in certain situations where medical records must be provided to establish medical necessity before the plan will pay for the service. Services are subject to eligibility and benefits at the time of service.

Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition based on national, evidence-based guidelines. Premera and Microsoft reserve the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

Temporomandibular joint (TMJ) dysfunction

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers treatment of temporomandibular joint (TMJ) dysfunction and other related disorders, such as myofascial pain dysfunction (MPD). Services must be rendered by a physician, hospital, licensed or registered physical therapist, or licensed dentist.



For TMJ services, pre-service review requests should be faxed to Dental Review at (425) 918-5956 or mailed to:
Dental Review
MS 173
P.O. Box 91059
Seattle, WA, 98111-9159

TMJ services and supplies for the treatment of TMJ dysfunction and myofascial pain dysfunction include:

- Diagnostic and follow-up examinations
- Diagnostic X-ray services
- Oral surgery
- Physical therapy
- Biofeedback
- Transcutaneous Electrical Nerve Stimulation (TENS)
- TMJ splints or TMJ guards

Transfusions, blood, and blood derivatives

In-network: 90%, deductible applies

Out-of-network: 90%, deductible applies

This benefit covers transfusions, blood, and blood derivatives that are not replaced by voluntary donors. The cost of donating and storing your own blood for a planned surgery is also covered.

Transgender services

In-network: 90%, deductible applies

Out-of-network: 90% of allowable charges, deductible applies

This benefit covers medically necessary transgender surgical services, including facility and anesthesia charges related to the surgery.

Coverage of prescription drugs and mental health treatment associated with gender reassignment surgery is available under the [prescription drugs](#) and [mental health](#) benefits.

Who is eligible

Surgical gender reassignment services will be considered medically necessary and covered if all the following criteria are met:

- For all surgical procedures recognized as medically necessary in the most current Standards of Care published by the World Professional Association for Transgender Health (WPATH), other than genital and breast surgery, benefits are available if you are at least 18 years old and diagnosed as having gender dysphoria
- For breast/chest surgery you must meet the above and have one letter of recommendation for surgery from a mental health professional
- For genital surgery you must meet the first criterion and the following criteria as well:
 - You have been an active participant in a recognized gender identity treatment program and have successfully lived and worked within the desired gender role full time for at least 12 months
 - You have received recommendations for surgery from two separate mental health professionals, at least one of which includes an extensive report. One Master's degree-level professional is acceptable if the second letter is from a psychiatrist or PhD clinical psychologist.

Prior Authorization

Prior authorization, also referred to as a pre-service review, is recommended to determine coverage is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.



Prior authorization is an advance determination by Premera that the service is medically necessary and that the member's plan has benefits available for the service being requested. This determination is offered in certain situations where medical records must be provided to establish medical necessity before the plan will pay for the service. Services are subject to eligibility and benefits at the time of service.

Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition based on national, evidence-based guidelines. Premera and Microsoft reserve the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

For transgender services, the prior authorization should include:

- The surgical procedure(s) for which coverage is being requested
- The date the procedure will be performed
- Information supporting the criteria listed above has been met, based on the surgery being requested



Your physician can fax this information to (800) 843-1114 or mail it to:

Premera Blue Cross
Attn: Integrated Health Management
P.O. 91059
Seattle, WA
98111-09159

Transplants

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers solid organ transplants and bone marrow/stem cell reinfusion—procedures cannot be experimental or investigative.



Experimental or investigational services, equipment, and drugs have not been approved by the U.S. Food and Drug Administration (FDA) for the specified use. Review the [glossary](#) for a full definition.



The transplant benefit doesn't cover cornea transplantation, skin grafts, or the transplant of blood or blood derivatives (except for bone marrow or stem cells). These procedures are covered on the same basis as any other covered surgical procedure.

Eligible providers

To be eligible for coverage, the transplant or reinfusion must be furnished in an approved transplant center that has developed expertise in performing solid organ transplants, bone marrow reinfusion, or stem cell reinfusion, and is approved by Premera. Premera has contractual agreements with approved transplant centers, and has access to a special network of approved transplant centers, throughout the United States. Whenever medically possible, we will direct you to an approved transplant center with which Premera has a contract. Of course, if neither a Premera-approved transplant center nor a Premera network transplant center can provide the type of transplant you need, this benefit will cover a transplant center that meets the approval standards that are set by Premera.



Approved transplant center is a hospital or other provider that has developed expertise in performing covered transplant services and has a contractual agreement in place with Premiera. Review the [glossary](#) for a full definition.

Donor costs

All donor acquisition costs such as selection (testing and typing), harvesting (removal) transportation of donor organ, bone marrow and stem cells, and storage costs for bone marrow and stem cells for a period of up to 12 months are covered services, including costs incurred by the surgical harvesting teams.

Expenses for transportation, lodging, and meals

Expenses for transportation, lodging, and meals for the transplant recipient (while not confined) and one companion, except as stated below, are covered but limited as follows:

- The transplant recipient must reside more than 50 miles from the approved transplant center unless the treatment protocols are medically necessary and require the member to remain closer to the transplant center
- The transportation must be to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure, or post-discharge follow-up
- When the recipient is a dependent minor child, benefits for transportation, lodging, and meal expenses for the recipient and two companions will be provided at 100% (deductible applies), up to a maximum of \$125 per day
- When the recipient is not a dependent minor child, benefits for transportation, lodging, and meal expenses for the recipient and one companion will be provided at 100% (deductible applies), up to a maximum of \$80 per day

Additional exclusions and limitations for transplants

In addition to the plan's [Exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- Nonhuman or mechanical organs, unless they are not experimental or investigative
- Services and supplies that are payable by any government, foundation, or charitable grant. This includes services performed on potential or actual recipients or donors (living or cadaver).
- Donor costs are not covered if the recipient of the transplant service is not a Microsoft enrollee. This applies to donor costs for all types of transplant services, solid organ and bone marrow or stem cell reinfusion.
- Donor costs are not covered by Microsoft if benefits are available under other group or individual coverage
- Donor costs are not covered for transportation for typing or matching

Vision therapy

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

Limit: up to 32-visit lifetime benefit maximum

This benefit covers vision training, eye training or eye exercises up to a lifetime benefit maximum of 32 treatment visits for the following conditions only:

- Amblyopia
- Convergence insufficiency
- Esotropia or exotropia

All other uses of vision therapy are considered investigative and are not covered. Vision therapy is not a covered service under the [Vision plan](#). Costs of equipment and supplies associated with vision therapy are not covered.

Weight Management program

In-network: 80%, up to \$6,000 lifetime benefit maximum, deductible and coinsurance maximum does not apply

Out-of-network: not applicable

This benefit covers comprehensive and clinically based weight management programs for the treatment of obesity. The 20% coinsurance you pay will not count toward the deductible or coinsurance maximum and will continue after the deductible and coinsurance are met.

Who is eligible

Members are eligible for this benefit if they meet the following criteria:

- Diagnosed as obese (commonly Body Mass Index (BMI) greater than or equal to 30)
- Overweight with a BMI greater than or equal to 27, and diagnosed with two or more of the following conditions:
 - Congestive heart failure
 - Coronary heart disease
 - Depression
 - Diabetes
 - Hyperlipidemia
 - Hypertension

Dependent children are not eligible for this benefit.

Eligible providers

Approved [weight management providers](#) of this benefit must meet eligibility requirements set forth by Microsoft and Premera and be providing services under a weight management program that is contracted for and approved by Premera for this plan.

Approved weight management programs will be those programs that are comprehensive and clinically based. Approved programs must be based on medical oversight and include treatment from professionals in the areas of nutrition, behavioral therapy, and personal training. An approved program must include an initial minimum 10-week period of frequent sessions with the program's physician, personal trainer, dietician, and behavioral therapist. This initial period must be followed by a minimum three-month maintenance period, which includes regular follow-up visits with these program professionals.

The Weight Management program must be contracted for and approved by Premera both at the time the participant or covered spouse/domestic partner begins the program and when he or she completes the program. If the program is not approved and contracted for until after the participant has started treatment under the program, no part of the cost of the program will be covered under this benefit.



To find an approved provider, review the [Weight Management providers](#) list.

Prior Authorization

Prior authorization, also referred to as a pre-service review, is recommended to determine coverage is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.



Prior authorization is an advance determination by Premera that the service is medically necessary and that the member's plan has benefits available for the service being requested. This determination is offered in certain situations where medical records must be provided to establish medical necessity before the plan will pay for the service. Services are subject to eligibility and benefits at the time of service.

Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition based on national, evidence-based guidelines. Premera and Microsoft reserve the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

A [Weight Management Recommendation form](#) or confirmation of your BMI and co-morbid conditions should be submitted to Premera prior to receiving reimbursement from Premera. Your physician's recommendation will confirm you meet the contract criteria required for this benefit to be available.

The following are the steps that must be completed to ensure that your treatment meets the criteria of this benefit:

1. Take the Weight Management Recommendation form to your regular physician
2. An evaluation is performed by your physician to determine if you meet the eligibility requirements set forth above
3. Your physician faxes or mails the Weight Management Recommendation Form to Premera Care Facilitation to confirm that you meet the weight management eligibility requirements and your physician's approval



Your physician can fax this information to (800) 866-4198 or mail it to:

Premera Blue Cross
Attn: Care Facilitation
P.O. 91059
Seattle, WA 98111-9159

4. Premera will review the information submitted and verify the coverage through a prior authorization

Participation in the program should begin within six months of the prior authorization being issued or a new prior authorization will need to be requested.

Claims payment

Final claims payment will be contingent on Premera receiving all biometric reporting information for the participant. Reimbursement for this benefit may occur in one of two ways. The program you attend will select the claims payment method used.

Method 1: Direct reimbursement to member

The provider will bill you directly for services provided. The frequency of billing should be made clear by the provider before you start the program. The weight management provider may collect a deposit from you to initiate your participation in the program.

During the course of the program you can submit an interim weight management billing claim form on a monthly or quarterly basis to Premera for reimbursement. You may also submit a final weight management final billing claim form at the end of the program.

If your coverage terminates during the time you are participating in an approved program, and you do not elect COBRA, only services rendered up to the date of termination of coverage will be reimbursed.

Method 2: Direct reimbursement to provider

Reimbursement will be made directly to the weight management provider on a monthly or quarterly basis. The weight management provider may collect a deposit from you to initiate your participation in the program, but will bill Premera on a monthly or quarterly basis for your ongoing participation.

Additional exclusions and limitations for Weight Management program

In addition to the plan's [Exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- Food
- Nutritional supplements (i.e., protein shakes)
- Drugs or surgical procedures to assist in reducing weight or curbing hunger

X-rays

In-network: 90%, deductible applies

Out-of-network: 90% of allowable charges, deductible applies

This benefit covers diagnostic X-rays, including the administration and interpretation, when ordered by a licensed physician.

Exclusions and limitations

- Services or supplies not medically necessary for diagnosis, care, or treatment of a disease, illness, injury, or medical condition, except for the following: (a) newborn nursery care covered under the hospital benefit; (b) male circumcision benefit; (c) sterilization benefit; (d) termination of pregnancy benefit; (e) infertility benefit; (f) hospice care benefit; and (g) well-child care and adult physical exam benefits
- Charges in excess of eligible charges, including out-of-network provider billed amounts over the allowable charges
- Expenses in excess of the applicable annual and lifetime benefit maximums
- Services for which claim was not received by Premera within 12 months of the date of service. Corrected claims and COB claims need to be submitted within 12 months from the original claim submission date.
- Over-the-counter drugs (unless prescribed), food dietary supplements (for example, infant formulas or protein supplements); herbal or naturopathic/homeopathic medicine are not covered
- Over-the-counter (OTC) testing and supplies (for example, OTC pregnancy test and ovulation tests) except as covered under the DME benefit
- Charges for or in connection with services or supplies that are determined to be experimental or investigational
- Benefits that overlap or duplicate benefits for which the member is eligible under any other group benefit plan; Workers' Compensation or similar employee benefit law; Medicare A or B; or government-sponsored program of any type
- Services or supplies that are covered through any type of no-fault coverage or similar type of insurance coverage or contract, including boat policies, motor vehicle, Personal injury protection (PIP), Medical payments (MEDPAY), Medical Premise for homeowners or commercial (MEDPREM) or excess medical coverage
- Work-related Conditions: This exclusion applies whether or not a proper or timely claim for benefits has been made under the following programs. This plan does not cover services or supplies for which you are entitled to receive benefits under:
 - Occupational coverage required of, or voluntarily obtained by, the employer
 - State or federal workers' compensation acts
 - Any legislative act providing compensation for work-related illness or injury
- In the event that you do not comply with the contractual terms of subrogation, the plan will no longer be obligated to provide any benefits under this plan. The plan has the right to deduct the amount of benefits paid from any future benefits payable to the enrollee or to any other covered dependent.
- Any services or supplies for which no charge is made, or for which a charge is made because this plan is in effect, or for services or supplies for which the member is legally liable because this plan is in effect
- Services of a social worker except as provided in the hospice care benefit, the home health care benefit, and the mental health and chemical dependency benefit

- Routine or palliative foot care to treat fallen arches, flat feet, care of corns, bunions (except for bone surgery), calluses, toenails (except for ingrown toenail surgery) and other problems that are commonly treated with off-the-shelf, over-the-counter (OTC) therapy. This exclusion does not apply to enrollees who are diabetic.
- Foot or shoe prosthetics, appliances, orthotics or inserts except as described under the durable medical and surgical equipment and supplies benefit. This does not apply to enrollees who are diabetic.
- Massage therapy that is not medically necessary and without a prescription
- Hearing exams, hearing aids, services for mental conditions, substance abuse, alcoholism, cosmetic services, organ, bone marrow, and stem cell transplants, infertility, vision therapy, and surgical weight loss treatment, except as provided under the specific benefits for these conditions
- Liquid diets or fasting programs, **memberships in diet programs or health clubs**, or wiring of the jaw
- Drugs and medications not approved by the Food and Drug Administration (FDA) except as defined in the Experimental and Investigational section
- Procedures for sterilization reversals
- Hypnotherapy, regardless of provider
- Hippotherapy or other forms of equine or animal-based therapy
- Electronic services and/or consults, except as covered under the physicians' benefit and mobile medicine program
- Services or supplies furnished by a member to himself or herself or by a provider who is in any way related to the member. This also includes covered dependents under the plan who are living within the member's household
- Services that are outside the scope of the provider's license or certification, or that are furnished by a provider that is not licensed or certified by the jurisdiction in which the services or supplies were received
- Separate charges for records or reports, except those Premera requests for utilization review
- Voluntary support or affinity groups such as patient support, **diabetic support groups** or Alcoholics Anonymous. Additionally, volunteer services or services provided by or through a school, books, and other training aids are also not covered.
- Non-treatment facilities, institutions or programs: Benefits are not provided for institutional care, housing, incarceration or programs from facilities that are not licensed to provide medical or behavioral health treatment for covered conditions. Examples are prisons, nursing homes, juvenile detention facilities, group homes, ~~foster~~ **homes** and adult family homes. Benefits may be provided for medically necessary treatment received in these locations if treatment is provided by an **eligible provider**.
- **Services or supplies for any of the following:**
 - Education and training programs including testing or supplies/materials, including vision training supplies
 - **Educational or recreational therapy or programs; this includes, but is not limited to boarding schools and wilderness programs. Benefits may be provided for medically necessary treatment received in these locations if treatment is provided by an eligible provider.**
 - Social, cultural, or vocational rehabilitation or vision training supplies
 - Sexual dysfunction disorders and/or defects, whether or not the consequence of illness, disease, or injury, such as impotence, frigidity, or sexual addiction, except as specified in the **cosmetic and reconstruction surgery** benefit or the **prescription drug** benefit
- Refractive surgery of the eye (surgery to improve vision that can be corrected with glasses or contact lenses) is covered only as specified under the vision plan

- Over-the-counter breast pumps intended for use in the home will be covered at 100% of allowable charges; deductible does not apply; however, hospital grade breast pumps are not covered except when used in an inpatient setting
- Services for individuals not eligible for coverage under the Microsoft Plan will not be reimbursed except in the following circumstances:
 - Donors for organ or bone marrow/stem cell transplantation for services specific to that procedure
 - Testing and treatment of infertility performed on surrogates when the same services would be covered if performed on member; testing and treatment for selection of a surrogate or potential surrogates is not covered
 - Genetic testing of relatives when the information is needed to adequately assess risk in the member; the result of the test will directly impact the treatment to the member; and there is no other coverage available to the relative
- Lodging is covered only as outlined in the transplant benefit
- When Coordinating Benefits (COB) if you fail to follow the rules of the primary plan, this plan would pay nothing for that expense
- Benefits are not provided for services or supplies (1) for which no charge is made, (2) for which no charge would have been made if this plan were not in effect or (3) that were not received by the member while covered by the plan
- Services received in excess of a benefit limit or maximum are not covered. Any network discounts for in network providers do not apply to services received in excess of the benefit limit.

In addition, certain exclusions and limitations apply to the following benefits. CTRL+Click to navigate to the benefit information.

- [Autism/ABA therapy](#)
- [Dental services](#)
- [Hearing care and hardware](#)
- [Home health care](#)
- [Hospice care](#)
- [Hospital inpatient care](#)
- [Infertility](#)
- [Medical and surgical equipment and supplies](#)
- [Mental health and chemical dependency treatment](#)
- [Prescription drugs](#)
- [Skilled nursing facility](#)
- [Transplants](#)
- [Weight Management program](#)

How to file a claim

In most cases, when you receive care from an in-network provider, your provider will submit bills directly to Premera, and this submission is your claim for benefits. If your provider does not submit a bill directly to Premera, you will need to submit a claim for benefits.

If possible, you should submit the claim form within 30 days of the service. The plan will not reimburse claims submitted more than 12 months after the date of service.

To submit a claim:

1. Download the [Premera claim form](#) or e-mail Premera at microsoft@premera.com to request a claim form.
2. Complete the claim form, including all of the following information:
 - a. Your name and the member's name
 - b. Identification numbers shown on your identification card (including the alpha 3-digit, or MSJ)
 - c. Provider's name, address, and tax identification number
 - d. If you are seeking secondary coverage from the Microsoft health plan, information about other insurance coverage related to the claim at hand, including a copy of their Explanation of Benefits (EOB), if applicable
 - e. If treatment is as a result of an accident: the date, time, location and brief description of the accident
 - f. Date of onset of the illness or injury
 - g. Date of service
 - h. Diagnosis or ICD-10 code (this information can be found on the provider bill)
 - i. Procedure codes (CPT-4, HCPCS, ADA, or UB-92) or descriptive English language for each service (this information can be found on the provider bill)
 - j. Itemized charges for each service rendered by provider
3. Sign the form in the space provided and attach the itemized provider bill
4. Mail the completed form to:

Premera Blue Cross
 P.O. Box 91059
 Seattle, WA 98111-9159
 Fax (800) 676-1477
 Email for claims: Microsoft@premera.com



COBRA-eligibility claims should be submitted as described in the [Continuation of coverage for health benefits](#) section.

In the following circumstances, you may submit claims according to the [appeals process](#):

- *If you cannot submit the claim in a timely manner due to circumstances beyond your control*
- *If your claim regards plan eligibility for you, your spouse/domestic partner, or dependent child*

Claim review and payment

Premera will send you an Explanation of Benefits (EOB) or other communication notifying you of their decision on your claim no more than 30 days after Premera receives the claim. Premera may extend this 30-day period for up to 15 days if the extension is required due to matters beyond the control of Premera.



Explanation of benefits (EOB) is the statement you receive from Premera Blue Cross detailing how much the provider billed, how much (if any) the plan paid, and the amount that you owe the provider (if any).

You will have at least 45 days to provide any additional information requested of you by Premera, if an extension is required due to Premera needing additional information from you or your health care providers.

Premera will make a payment to the employee, a dependent (age 13 or older), a provider, or another carrier. Payments are subject to applicable law and regulation:

- Premera may make payments on behalf of an enrolled child to a non-enrolled parent or state agency to which the plan is required by applicable law to direct such payments
- Payments made will discharge the plan to the extent of the amount paid, so that the plan is not liable to anyone due to its choice of payee

Denied claims notice

If all or part of your claim is denied, Premera will send you an Explanation of Benefits (EOB) or other notice with the following information:

- The specific reason or reasons for the denial
- Reference to the specific plan provisions on which the denial is based
- A description of any additional material or information needed from you and the reason it is needed
- An explanation of the appeals procedures and the applicable time limits
- A statement regarding any internal rule, guideline, protocol or other criterion that was relied upon in making the adverse determination (a copy of which will be provided free upon request)
- If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment that led to this determination (a copy of which will be provided free upon request)
- If the claim is an urgent care claim (as defined under law), a description of the expedited review process applicable to such claims
- If you have filed a claim with Premera relating to plan eligibility, and this claim is denied, Premera will send you a notice explaining your appeal rights
- Notice regarding your right to bring legal action following a denial on appeal

For medical and transplant benefits, the denial will also include:

- Information sufficient to identify the claim involved, including the date of service, health care provider and claim amount, if applicable
- The denial code and its meaning
- A description of the plan's standard for denying the claim
- Information regarding available internal and external appeals, including how to initiate an appeal
- Contact information for Premera Customer Service or the Employee Benefits Security Administration (EBSA) of the U.S. Department of Labor to assist participants with the internal and external appeals process

Appeal for internal review

If the plan denies your claim, you may appeal for an internal review of the decision within 180 days of receiving the Explanation of Benefits (EOB).



An **appeal** is a written request to reconsider a written or official verbal adverse determination to deny, modify, reduce or end payment, coverage or authorization of health care coverage or eligibility to participate in the plan. This includes admissions to and continued stays in a facility. The process also applies to Flexible Spending Account appeals for reimbursement but does not apply to appeals of denied COBRA eligibility claims.



If you fail to file the internal appeal within 180 days of receiving the Explanation of Benefits, you will permanently lose your right to appeal the denied claim.

Submitting an appeal for internal review

You or your authorized representative must provide the following information as part of your written appeal to the Premera Appeals Department.

- Your name
- Your Premera member number
- The name of this plan, and
- A concise statement of why you disagree with the decision, including facts or theories supporting your claim

Your written request may (but is not required to) include issues, comments, documents, and other records you want considered in the review.



The appeal should be submitted to Premera at the following address:

Appeals Coordinator
Premera Blue Cross
P.O. Box 91102
Seattle, WA 98111-9202

You may, at your own expense, have a representative act on your behalf. If you want to appoint someone to act for you in the appeals process (including your provider), you must submit a completed and signed [Premera Internal Appeals Authorization form](#) with your written appeal for internal review to the appeals coordinator at the address above.

In the case of an urgent care appeal, you may submit your appeal request in writing and all necessary information may be transmitted between you and the plan by fax. If your provider believes your situation is urgent as defined under law and so notifies Premera, your appeal will be conducted on an expedited basis. Notification will be furnished to you as soon as possible, but not later than 72 hours after receipt of the expedited appeal. Your appeal should clearly indicate your request for an expedited appeal.

For urgent situations or if you are in an ongoing course of treatment, you may begin an external independent review at the same time as Premera Blue Cross's internal review process if this is an urgent situation or you are in an ongoing course of treatment. The external review agency is not legally affiliated or controlled by Premera. The external review agency decision is final and is generally binding upon the Plan.



To file an urgent care appeal request, you may fax a request to (425) 918-5592.



The external review for non-urgent situations is available only after you have properly exhausted the internal appeal as described above.



An urgent situation means one in which your provider concludes that the application of the standard time periods for making determinations could seriously jeopardize your life or health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

The new definition of urgent is as follows:

If your provider believes the situation meets the definition of urgent under the law and we agree, your review will be conducted on an expedited basis. If you are currently in the hospital, you have the right to an expedited appeal and we will review your case and provide you with a decision within 24-72 hours.

We will not expedite your appeal if you have already received the services you are appealing, or if you do not meet the above requirements.

Internal review and timeframe

All the information you submit will be taken into account on appeal, even if it was not reviewed as part of the initial decision. You may ask to examine or receive free copies of all pertinent plan documents, records, and other information relevant to your claim by asking Premera.

The plan may consult with a health care professional who has experience in the field of medicine involved in the medical judgment to decide your appeal. You may request the identity of medical experts whose advice was obtained by the plan in connection with your initial claim denial, even if their advice was not relied upon in making the initial decision.

In the event any new or additional information (evidence) is considered, relied on or generated by Premera in connection with your appeal, Premera will provide this information to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Premera, Premera will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that that you will have an opportunity to respond.

If you have not had the service yet these are considered pre-service appeals, we will send a decision no later than 30 calendar days after receipt of your appeal request.

If you have already had the service these are considered post service appeals, we will send a decision no later than 60 calendar days after receipt of your appeal request.

Denied appeal notice

If your appeal is denied, you will receive a written notice setting forth:

- The specific reason or reasons for the denial
- Reference to the specific plan provisions on which the denial is based
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits
- A statement explaining the external review procedures offered by the plan and your right to bring a civil action under ERISA section 502(a)
- A statement regarding any internal rule, guideline, protocol or other criterion that was relied upon in denying the claim (a copy of which will be provided free upon request)
- If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment that led to this determination (a copy of which will be provided free upon request)

For medical and transplant benefits, the denial will also include:

- Information sufficient to identify the claim involved, including the date of service, health care provider and claim amount, if applicable
- The denial code and its meaning
- A description of the Plan's standard for denying the claim
- Information regarding available internal and external appeals, including how to initiate an appeal
- Contact information for Premera Customer Service or the Employee Benefits Security Administration (EBSA) of the U.S. Department of Labor to assist participants with the internal and external appeals process

Appeal for external review

If you are not satisfied with the final internal denial of your claim, you may request an external review by an independent review organization (IRO) if that denial is based on medical judgment including:

- Requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit
- A determination that a treatment is experimental or investigational



An **independent review organization (IRO)** is an independent organization of medical experts who are qualified to review medical and other relevant information.

The external review is for non-urgent situations is available only after you have properly exhausted the internal appeals process as described above. There are no fees or costs imposed on you as part of the external review.

The external review agency decision is final and is generally binding upon the plan.

Submitting an appeal for external review

An [External Review Request form](#) will be sent with your internal appeal determination letter notifying you of your rights to an external review.

To initiate the external review, you must complete and sign the form and send it to Premera at the address below no later than 120 days after the date you receive your internal appeal determination letter, which the plan deems to be seven days after the date on the internal appeal determination letter.



If you fail to submit the completed and signed form within this timeframe, you will permanently lose your right to an external review.



Mail the External Review Request form to:

Premera Blue Cross
Attn: Microsoft Member Appeals – IRO Mail Stop 123
P.O. Box 91102
Seattle, WA 98111-9202

External review and timeframe

If your appeal is eligible for external review, Premera will notify the IRO of your request for an external review and send them all the information included in your internal appeal and other relevant materials within six days of receipt.

The IRO will contact Premera directly if additional information is needed. Premera will provide the IRO with any additional information they request that is reasonably available. The external review request is considered complete when the IRO has all the requested information and the IRO review begins.



If your provider believes your situation is urgent under law (as defined above under Appeal for internal review), your external review will be conducted on an expedited basis. For expedited external reviews, you and Premera will be notified by phone, e-mail message or fax as soon as possible, but no later than 72 hours after receipt of your external review request. A written determination will follow.

The plan agrees that any statute of limitations (including the one-year contractual limitations period described below) or other defense based on timeliness is on hold during the time that the external review is pending. Your decision whether to file the external review will have no effect on your rights to any other benefits under the plan.

The external review process does not apply to appeals of denied claims for plan eligibility or for other appeals of denied claims that are not based on medical judgment.

Decision on the external review

The plan is bound by the IRO's decision. If the IRO overturned the final internal adverse determination, the plan will implement their decision. The IRO will notify you and Premera in writing of its determination on the external review no later than 45 days after receipt of your complete external review request.

Decisions upon the external review are the final decision under the plan's appeal process, and there are no further appeals available from Premera or Microsoft or any person administering claims or appeals under the plan. However, you still have the right to file suit under ERISA Section 502(a) as a result of the external review decision.

Limits on your right to judicial review

You must follow the appeals process described above through the decision on the appeal before taking action in any other forum regarding a claim for benefits under the plan. Any legal action initiated under the plan must be brought no later than one year following the adverse determination on the appeal. This one-year limitations period on claims for benefits applies in any forum where you initiate legal action. If a legal action is not filed within this period, your benefit claim is deemed permanently waived and barred.



If you have questions about understanding a denial of a claim or your appeal rights, you may contact Premera Customer Service for assistance at (800) 676-1411. You may also seek assistance from the Employee Benefits Security Administration (EBSA) of the U.S. Department of Labor at (866) 444-EBSA (3272).

Right to recover benefits paid in error

If Premera makes a payment in error on your behalf to you or a provider, and you are not eligible for all or a part of that payment, Premera has the right to recover payment, including deducting the amount paid mistake from future benefits.

Note: Health care providers are not “beneficiaries” of the plan, and although Premera may make direct payment to health care providers for the convenience of participants and their dependents, such payments of services shall not be considered “benefits” available under the plan, or confer beneficiary standing upon a health care provider.

Notice of information use and disclosure

Premera may collect, use, or disclose certain information about you. This protected personal information (PPI) may include health information, or personal data such as your address, telephone number, or Social Security number. Premera may receive this information from, or release it to, health care providers, insurance companies, or other sources.

This information is collected, used, or released for conducting routine business operations such as:

- Underwriting and determining your eligibility for benefits and paying claims
- Coordinating benefits with other health care plans
- Conducting care management, case management, or quality reviews
- Fulfilling other legal obligations that are specified under the Group Contract



Case management is a service to help ensure that you receive appropriate and cost-effective medical care. Review the [glossary](#) for a full definition.

This information may also be collected, used, or released as required or permitted by law.

To safeguard your privacy, Premera takes care to ensure that your information remains confidential by having a company confidentiality policy and by requiring all employees to sign it.

If a disclosure of PPI is not related to a routine business function, Premera removes anything that could be used to easily identify you or we obtain your prior written authorization.

You have the right to request inspection and/or amendment of records retained by Premera that contain your PPI.



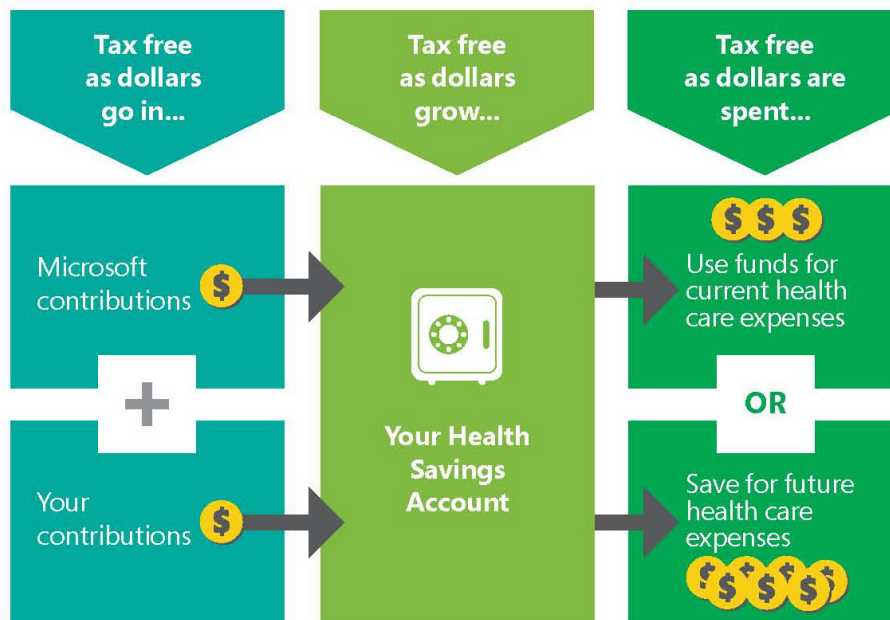
Please contact the Premera Customer Service department at (800) 676-1411 and ask a representative to mail a request form to you.

Health Savings Account (HSA)

The Health Savings Account is an interest-bearing savings account designed to allow you to pay for medical expenses (both now and in the future) with tax-free dollars. The Health Savings Account is yours—you own, manage, and control the funds in the account. If you do not spend it, you get to keep it, and you can watch it grow over time.

The Health Savings Account is available only to those enrolled in a high-deductible health plan, such as the Health Savings Plan, that meets certain Internal Revenue Service (IRS) criteria.

The Health Savings Account features triple tax savings—tax-free contributions into your account, tax-free earnings on interest and dividends, and tax-free when you withdraw funds to pay for eligible health care expenses.



Visit the [Health Savings Plan](#) section on the Benefits site for more information.

Setting up your account

Microsoft and Premera work with UMB Bank, the bank trustee, to administer your Health Savings Account. Once you enroll in the Health Savings Plan, Microsoft will open a Health Savings Account for you with UMB. Microsoft will pay for the initial account setup fee and monthly access fee while you are covered under the plan as an active employee. You are responsible for paying any additional fees you incur. You may also establish an account at another bank and transfer the funds from the UMB Bank account.

Eligibility to contribute to an HSA

You are eligible for a Health Savings Account if:

- You are enrolled in a Health Savings Account-compatible, high-deductible health plan (such as the Premera Health Savings Plan offered by Microsoft)
- You are not covered by another health plan (other than another high-deductible health plan), including coverage under your spouse's/domestic partner's health plan
- Your spouse does not have a Health Care Flexible Spending Account (FSA) or Health Reimbursement Arrangement (HRA)

- You cannot be claimed as a dependent on another person's tax return
- You are not enrolled in Medicare (parts A, B, C or D) or TRICARE, and you have not received medical or prescription benefits from the Veteran's Administration (VA) in the preceding three months (Note: mere eligibility for medical benefits from the Veteran's Administration does not disqualify you from participating in the HSA.)



You still have medical coverage under the Health Savings Plan even if you cannot contribute to a Health Savings Account.

If you do not qualify for a Health Savings Account because you have coverage under another health plan, you or your spouse/domestic partner can take action if you wish to address your eligibility issue.

- If you are covered by your spouse's/domestic partner's health plan, you should have him/her remove you as a covered dependent and/or withdraw from his or her health care FSA/HRA
- If you are enrolled in Medicare or TRICARE (medical), or if you have received VA medical/prescription benefits in the past three months, you are not eligible for the Health Savings Account and typically you cannot take action to address your eligibility issue. In these circumstances, Microsoft will provide you with an alternative cash contribution, equal to the annual Health Savings Account contribution for your coverage level, via paycheck deposit.

Microsoft will discontinue all employer contributions to the Health Savings Account when you are no longer covered under the plan as an active Microsoft employee or if you are covered by disqualifying coverage under another health plan.



If you continue medical coverage in the Health Savings Plan through COBRA, you will not continue to receive Microsoft contributions to your Health Savings Account.

Contributions to your Health Savings Account

Microsoft will make a pre-tax contribution to your Health Savings Account (for active employees only) based upon your coverage level, as outlined in the table below. The Microsoft contribution is deposited in two equal installments in January and July. Microsoft contributions to the Health Savings Account are prorated on a per pay period basis, if you are enrolled in the plan for only part of the year.

You may make additional tax-free contributions to your account. If you and your spouse both have high deductible health plan family coverage, the combined contribution of the spouses may not exceed the annual family coverage contribution limit (that is, \$6,750 in 2016). Individuals over age 55 may make an additional annual catch-up contribution as listed below.

Due to IRS regulations, the annual combined Microsoft/employee tax-free contribution to the Health Savings Account cannot exceed the maximum annual limits listed in the table below.

Annual tax-free contribution limits for the Health Savings Account				
		Microsoft contribution	Employee maximum contribution	Maximum annual limit
Level 59 and above	Employee only	\$1,000	\$2,350	\$3,350
	Employee + 1	\$2,000	\$4,750	\$6,750
	Employee + 2 or more	\$2,500	\$4,250	\$6,750
Level 58 and below	Employee only	\$1,500	\$1,850	\$3,350
	Employee + 1	\$3,000	\$3,750	\$6,750
	Employee + 2 or more	\$3,750	\$3,000	\$6,750
Over age 55 catch-up contribution		\$0	Maximum contribution plus \$1,000	Maximum contribution plus \$1,000



If you exceed the allowable maximum, excess contributions not removed before your tax filing deadline are subject to an additional 6% excise tax.

If both you and your spouse/eligible domestic partner are employed by Microsoft and enroll for coverage in the Health Savings Plan, certain rules apply to your HSA contributions from Microsoft.

- **If you enroll together under one plan**, the primary subscriber will receive the contribution from Microsoft to their Health Savings Account for your coverage level. Health care expenses for both you and your spouse/domestic partner will count toward the same deductible and coinsurance maximum.
- **If you enroll separately**, you will each receive the contribution from Microsoft for your coverage level in your own separate Health Savings Accounts. Health care expenses will count toward separate deductibles and coinsurance maximum amounts. You may keep dependent children with one parent only, or if you have more than one child, you may split them between the two parents.
- **If your Microsoft-employed domestic partner is not a qualifying tax dependent**, you may find it more beneficial to enroll separately so that he/she can have access to the tax saving benefits of the Health Savings Account. You will pay taxes if you use your Health Savings Account to cover expenses for a dependent who does not qualify as a dependent according to the IRS definition.

Microsoft will discontinue all employer contributions to the Health Savings Account when you are no longer covered under the plan as an active Microsoft employee or if you are covered by disqualifying coverage under another health plan.

Eligible expenses

The money in your Health Savings Account can be withdrawn on a tax-free basis to pay for qualified medical expenses, as defined by IRS section 223(d)(2) and section 213(d). If the amount withdrawn is used for something other than qualified medical expenses, then it will be subject to income tax and an additional 20% tax. For more information on tax treatment for Health Savings Accounts, refer to IRS Publication 969.

When you reach age 65, the funds in your Health Savings Account can be used for additional medical expenses, such as insurance premiums (Medicare Part A&B, Medicare Supplemental plans, and so on) and your share of retiree medical insurance premiums.

You are responsible for maintaining records of the medical expenses paid through the Health Savings Account. In the event of an IRS audit, you may need to provide documentation that the Health Savings Account was used for qualified medical expenses.

HMO Plan (Group Health Cooperative) – Washington only

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How the plan works

The Group Health Cooperative HMO Plan offers the convenience of “one-stop shop” medical care. Your providers are all part of the same integrated health care system so they can quickly share your medical records to help make informed decisions about your care. There is also a pharmacy, laboratory, and X-ray facility at every Group Health Cooperative location, so it is easy and efficient to get the care you need, when you need it.

Important notice under Federal Health Care Reform

Group Health recommends each member choose a Primary Care Physician. This decision is important since the designated Primary Care Physician provides or arranges for most of the member’s health care. The member has the right to designate any Primary Care Physician who participates in one of the Group Health networks and who is available to accept the member or the member’s family members. For information on how to select a Primary Care Physician, and for a list of the participating Primary Care Physicians, please call the Group Health Customer Service Center at (206) 901-4636 in the Seattle area, or toll-free in Washington, (888) 901-4636.

For children, the member may designate a pediatrician as the primary care provider.

The member does not need prior authorization from Group Health or from any other person (including a Primary Care Physician) to access obstetrical or gynecological care from a health care professional in the Group Health network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for obtaining prior authorization. For a list of participating health care professionals who specialize in obstetrics or gynecology, please call the Group Health Customer Service Center at 206-901-4636 in the Seattle area, or toll-free in Washington, (888) 901-4636.

Women’s health and cancer rights

If the member is receiving benefits for a covered mastectomy and elects breast reconstruction in connection with the mastectomy, the member will also receive coverage for:

- All stages of reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses.

- Treatment of physical complications of all stages of mastectomy, including lymphedemas.

These services will be provided in consultation with the member and the attending physician and will be subject to the same cost shares otherwise applicable under the Benefits Booklet.

Statement of rights under the Newborns' and Mothers' Health Protection Act

Carriers offering group health coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, carriers may not, under federal law, require that a provider obtain authorization from the carrier for prescribing a length of stay not in excess of 48 hours (or 96 hours). Also, under federal law, a carrier may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

For more information

Group Health will provide the information regarding the types of plans offered by Group Health to members on request. Please call the Group Health Customer Service Center at 206-901-4636 in the Seattle area, or toll-free in Washington, 888-901-4636.

Where you can get care

The Group Health Cooperative HMO Plan provides comprehensive medical care with several contracted providers, facilities and pharmacies through the Group Health Cooperative (Group Health) Network in Washington. Kaiser Permanente facilities are treated as part of the Group Health Network if you need medical services while outside Washington State.



In the event of unusual circumstances such as a major disaster, epidemic, military action, civil disorder, labor disputes or similar causes, Group Health will not be liable for administering coverage beyond the limitations of available personnel and facilities.

Services provided outside the Group Health Network may not be covered. The plan covers select services outside of the Group Health Network, including:

Covered care outside the Group Health Network	
Emergency care	You can obtain emergency care from the closest facility to you. You must call the Group Health hospital notification line at (888) 457-9516 within 24 hours of admission to a non-contracted facility, or as soon thereafter as medically possible. Please review the emergency benefits for more information.
Urgent care	If you are outside the Group Health service area, you may receive urgent care at any medical facility. Urgent care within the Group Health service area is covered at Group Health facilities. Please review the urgent care benefits for more information.

Covered care outside the Group Health Network	
Out of area travel benefit	If you are outside the Group Health service area, the plan covers services up to a maximum of \$2,000 per member per calendar year. All applicable costs, benefits, limitations and exclusions apply as if services were covered within the Group Health service area.
Prior authorization	Your primary care physician may refer you to a non-contracted provider outside the Group Health Network. Prior authorization must be provided by your primary care physician and approved by Group Health.



Urgent care is for the sudden, unexpected onset of a medical condition that is of sufficient severity to require medical treatment within 24 hours of its onset.

Primary care physician

You and your primary care physician coordinate your care with specialists and other members of the Group Health care team.

You should select a primary care physician for yourself and your covered dependents when you enroll in the Group Health Cooperative HMO Plan. You may select one physician for your entire family, or a different physician for each member. You can select or change your primary care physician by contacting Group Health Cooperative customer service at (206) 901-4636 or (888) 901-4636, or by visiting Group Health Cooperative online at <http://ghc.org/>. If your selected primary care physician is accepting patients, the change will be made within 24 hours of the request. If a primary care physician accepting new members is not available in your area, contact the Group Health Customer Service Center, who will ensure you have access to a primary care physician by contacting a physician's office to request they accept new members.

If your primary care physician no longer participates in Group Health Cooperative's network, you can use his or her services for up to 60 days after you've been sent a written notice about selecting a new physician.



A **Physician** is a state-licensed:

- Doctor of Medicine and Surgery (M.D.)
- Doctor of Osteopathy (D.O.)

In addition, professional services provided by one of the following types of providers may be covered under this plan, but only when the provider is providing a service that is within the scope of his or her state license and for which benefits are specified in this plan and would be payable if the service were provided by a physician as defined above:

- Chiropractor (D.C.)
- Dentist (D.D.S. or D.M.D.)
- Optometrist (O.D.)
- Podiatrist (D.P.M.)
- Psychologist (Ph.D.)
- Nurse (R.N.) licensed in Washington state
- Naturopathic physician (N.D.)



Call (206) 901-4636 or (888) 901-4636 or visit Group Health Cooperative online at <http://ghc.org> for a listing of personal physicians, referral specialists, women's health care providers, and Group Health Cooperative-designated specialists.

Specialist care

Unless indicated in the table below or the [What the plan covers](#) section, you will need a prior authorization from your primary care physician before the plan will cover care from specialists. To access a Group Health-designated specialist, consult your Group Health primary care physician, contact Customer Service for a list of Group-Health-designated Specialists, or view the Provider Directory located at www.ghc.org.

Specialty care that doesn't require a referral	
Group Health-designated specialists	Members may make appointments directly with most specialists at Group Health-owned or -operated medical centers without a referral. To obtain or request a complete list of these specialists, please contact GH Customer Service at (206) 901-4636 or view the Provider Directory located at www.ghc.org .
Women's health care direct access providers	<p>Female members may make appointments directly with specialists who are contracted by Group Health without a referral for the following care areas:</p> <ul style="list-style-type: none"> • Medically necessary maternity care • Covered reproductive health services • Preventive care (well care) and general examinations • Gynecological care • Follow-up visits with: General and Family Practitioners, Physician's Assistants, Gynecologists, Certified Nurse Midwives, Licensed Midwives, Doctors of Osteopathy, Pediatricians, Obstetricians, or Advanced Registered Nurse Practitioners who are contracted by Group Health <p>Care is covered as if your primary care physician has been consulted. However, if your provider diagnoses a condition that requires referral to other specialists or hospitalization, you must obtain prior authorization under Group Health requirements.</p>

Second opinions

You can get a second opinion on a medical diagnosis or treatment plan from a Group Health provider by visiting a Group Health-designated specialist. Second opinions are covered when prior authorization is received or when obtained from a Group Health-designated specialist.

Prior authorization for a second opinion does not imply that Group Health will authorize you to return to the physician providing the second opinion for additional treatment. Your coverage is determined by your medical plan benefits. Coverage for services, drugs, devices, etc., prescribed or recommended as a result of the consultation is determined by your medical plan benefits.



The Group Health medical director will determine the necessity, nature, and extent of treatment to be covered in each individual case, and the judgment will be made in good faith. You may refuse any recommended services to the extent permitted by law. If you obtain care not recommended by Group Health, you do so with the full understanding that Group Health has no obligation for the cost, or liability for the outcome, of such care. Your coverage decisions may be appealed under the plan benefits.

Process for medical necessity determination

Pre-service, concurrent or post-service reviews may be conducted. Once a service has been reviewed, additional reviews may be conducted. Members will be notified in writing when a determination has been made.

First level review

First level reviews are performed or overseen by appropriate clinical staff using Group Health approved clinical review criteria. Data sources for the review include, but are not limited to, referral forms, admission request forms, the member's medical record, and consultation with the attending/referring physician and multidisciplinary health care team. The clinical information used in the review may include treatment summaries, problem lists, specialty evaluations, laboratory and x-ray results, and rehabilitation service documentation. The member or legal surrogate may be contacted for information. Coordination of care interventions are initiated as they are identified. The reviewer consults with the requesting physician when more clarity is needed to make an informed medical necessity decision. The reviewer may consult with a board-certified consultative specialist and such consultations will be documented in the review text. If the requested service appears to be inappropriate based on application of the review criteria, the first level reviewer requests second level review by a physician or designated health care professional.

Second level (practitioner) review

The practitioner reviews the treatment plan and discusses, when appropriate, case circumstances and management options with the attending (or referring) physician. The reviewer consults with the requesting physician when more clarity is needed to make an informed coverage decision. The reviewer may consult with board certified physicians from appropriate specialty areas to assist in making determinations of coverage and/or appropriateness. All such consultations will be documented in the review text. If the reviewer determines that the admission, continued stay or service requested is not a covered service, a notice of non-coverage is issued. Only a physician, behavioral health practitioner (such as a psychiatrist, doctoral-level clinical psychologist, certified addiction medicine specialist), dentist or pharmacist who has the clinical expertise appropriate to the request under review with an unrestricted license may deny coverage based on medical necessity.

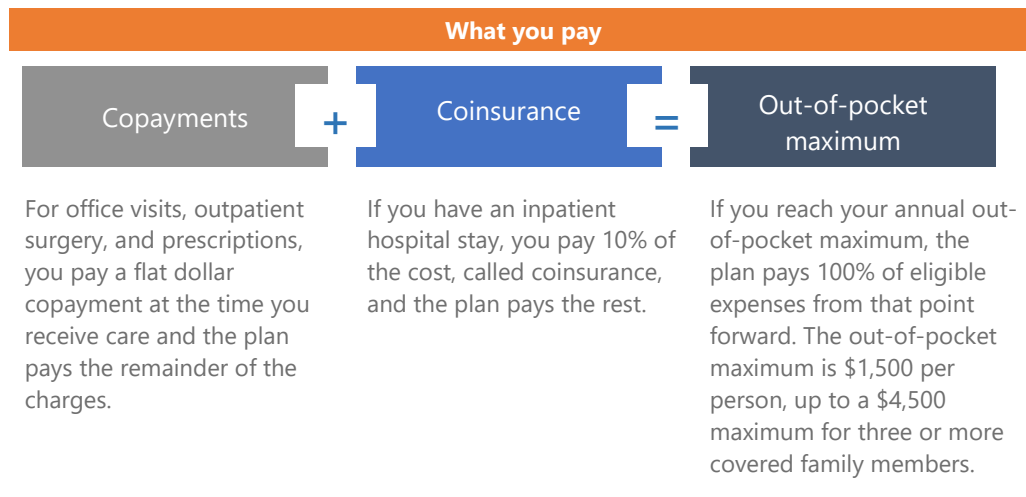
Filling a prescription

Depending on your needs, you may fill up to a 30-day supply of your prescription at a Group Health-designated pharmacy or up to a 90-day supply from Group Health's designated mail order service. Review the [prescription drugs](#) benefit for more information on what is covered.

What you pay

When you receive care for the treatment of illnesses, injuries, and chronic conditions, you pay a portion of the cost, up to an annual out-of-pocket maximum. For most services such as office visits, outpatient surgery, and prescriptions, you pay a flat copayment at the time you receive care and the plan pays the remainder of the cost. If you have an inpatient hospital stay, the plan pays 90% of the cost and you are responsible for 10% up to

an annual out-of-pocket maximum. When it comes to preventive care, the plan covers 100% when you use network providers.



Copayment is a fixed, up-front dollar amount that you're required to pay for certain covered services.

Coinsurance is the percentage amount that you are required to pay for certain covered services.

Out-of-pocket maximum is the most you could pay each plan year for covered services and supplies.

Medical care copayments

Type of visit	Copayment	Coinsurance
Primary Care Physician	\$20	None
Specialist	\$40	None
Emergency (waived if admitted)	\$75	None
Hospital – outpatient	\$100	None
Hospital – inpatient	None	10%

Prescription drug copayments

Type of prescription (30-day supply)	Group Health pharmacy copayment	Group Health mail order copayment
Value-based	\$0	\$0
Preferred generic	\$10	\$5
Preferred brand	\$25	\$20
Non-preferred generic and brand (when prescribed by Group Health provider)	\$50	\$45



Value-based drugs are drugs for chronic disease management such as diabetes, hyperlipidemia, heart failure and hypertension that are considered high value and are covered on a lower cost share tier.

Preferred generic drugs are equivalent to brand-name drugs but are available at a lower cost because the patent has expired.

Preferred brand-name drugs are sold under a trademark name. An equivalent generic drug may or may not be available at lower cost, depending upon whether the patent on the brand-name drug has expired.

The **Preferred drug list** is the list of brand-name prescription drugs that are covered under the Group Health Cooperative HMO Plan.



Call (206) 901-4636 or (888) 901-4636 or visit [Group Health Cooperative](#) online to review the Preferred drug list.

Out-of-pocket maximum

The annual out-of-pocket maximum is capped at \$1,500 for each covered member—this means that once a member reaches his/her out-of-pocket maximum through copayments and coinsurance, the plan pays 100% for the rest of the year for that individual. Also, if you have three or more covered family members, the most you'll pay for the year is \$4,500. Member payments for the Weight Management program do not count toward the out-of-pocket limit. All cost shares for covered services apply to the out-of-pocket maximum.

Utilization Management

All benefits under this plan are limited to covered services that are medically necessary and as set forth under Plan Benefits. Group Health Cooperative may review a member's medical records for the purpose of verifying delivery and coverage of services and items. Based on a prospective, concurrent or retrospective review, Group Health Cooperative may deny coverage if, in its determination, such services are not medically necessary. Such determination shall be based on established clinical criteria.

Group Health Cooperative will not deny coverage retroactively for services it has previously authorized and that have already been provided to the member except in the case of an intentional misrepresentation of a material fact by the patient, member, or provider of services, or if coverage was obtained based on inaccurate, false, or misleading information provided on the enrollment application, or for nonpayment of premiums.

What the plan covers

The table below summarizes the benefits of the Group Health Cooperative HMO Plan at Group Health facilities. You can refer to the details following this table for more information about benefit limits and cost sharing.

Group Health Cooperative HMO Plan provides benefits for routine patient costs of qualified individuals in approved clinical trials to the extent benefits for these costs are required by law. Routine patient costs include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Clinical trials require prior authorization.



Services and supplies must be medically necessary and are subject to all benefit exclusions and limitations and the plan's [Exclusions and limitations](#). You have the right to participate in decisions regarding your health care and you may refuse any recommended treatment or diagnostic plan to the extent permitted by law. If you obtain care not recommended by Group Health, you do so with the full understanding that Group Health has no obligation for the cost, or liability for the outcome, of such care. Your coverage decisions may be appealed under the plan Benefits.



CTRL+Click on the benefits below to access more information.

Common benefits

These are the most commonly used benefits in the Group Health Cooperative HMO Plan.

Benefit	Coverage
Preventive care Including well-baby care, well-child care routine gynecological exams, immunizations, female sterilization, FDA-approved contraceptive drugs, devices, including device removal, and counseling, preferred contraceptive drugs as recommended by the USPSTF when obtained with a prescription, and annual routine physical exams (see the Preventive Care Services list) and maintenance medications and chronic condition drugs (See the Preventive Drug list)	100%; includes well-baby care, child and adult routine exams, and maintenance medications
Prescription drugs	No copayment preventive; \$10 copayment preferred generic; \$25 copayment preferred brand; \$50 copayment non-preferred
Primary care office visit	\$20 copayment
Specialist office visit	\$40 copayment
Hospital care—inpatient Including semi-private room and board, anesthesia, supporting services, testing, supplies, and intensive or coronary care	90%
Hospital care—outpatient Including minor surgery, X-ray and radium therapy, anesthesia, and pre-admission testing	\$100 copayment
Urgent care	\$20 copayment for visits with primary care providers; \$40 copayment for visits with specialists
Rehabilitation and Habilitative Care – Physical, Occupational, Speech and Massage Therapies	Inpatient: 90%; up to 60 days combined per calendar year Outpatient: \$20 copayment for visits with primary care providers; \$40 copayment for visits with specialists; up to 60 visits combined per calendar year
Maternity and pregnancy care	Inpatient: 90% Outpatient: 100% for routine prenatal and postpartum visits; \$20 copayment for other visits with primary care providers; \$40 copayment visits with specialists

Common benefits	
These are the most commonly used benefits in the Group Health Cooperative HMO Plan.	
Benefit	Coverage
Mental health and substance abuse	<p>Inpatient: 90%</p> <p>Outpatient: through Microsoft CARES employee assistance program:</p> <ul style="list-style-type: none"> • 100% up to three visits per member per calendar year • 100% up to three telephonic counseling sessions per member per calendar year • 100% up to eight visits per family for family or couples counseling per calendar year <p>Then, \$20 copayment</p>

Other benefits	
The Group Health Cooperative HMO Plan also covers these additional benefits.	
Benefit	Coverage
Acupuncture	<p>\$20 copayment; up to a maximum of eight visits per member per medical diagnosis per calendar year without prior authorization; additional visits are covered with prior authorization</p> <p>No visit limit for treatment for Chemical Dependency</p>
Ambulance	90%
Chemical dependency	<p>Inpatient: 90%</p> <p>Outpatient: \$20 copayment for visits with primary care providers; \$40 copayment for visits with specialists; \$100 copayment for outpatient hospital care</p>
Detoxification services for alcoholism and drug abuse	<p>Inpatient: 90%</p> <p>Outpatient: \$75 copayment per visit to any emergency facility (copayment waived if admitted)</p>
Devices, equipment, and supplies	90%
Diabetic needs and supplies	<p>Insulin, needles, syringes, test strips and lancets covered under the prescription drug benefit</p> <p>90% for external insulin pumps, blood glucose monitors, and related supplies under the devices, equipment, and supplies benefit</p> <p>100% for diabetic retinal screening</p>
Dialysis (home and outpatient)	<p>Outpatient: \$20 copayment for visits with primary care providers; \$40 copayment for visits with specialists; \$100 copayment for outpatient hospital care</p>
Emergency care	\$75 copayment per visit to any emergency facility (copayment waived if admitted)
Hearing care and hardware	<p>\$20 copayment for visits with primary care providers; \$40 copayment for visits with specialists</p> <p>Hardware: 90%; \$3,000 hardware limit per member in a period of three consecutive calendar years</p>
Home health care	100%

Other benefits	
The Group Health Cooperative HMO Plan also covers these additional benefits.	
Benefit	Coverage
Hospice care	100%
Infusion therapy	Outpatient: \$20 copayment for visits with primary care providers; \$40 copayment for visits with specialists 100% for associated infused medications
Laboratory and radiology	100%
Manipulative therapy	\$20 copayment; up to a maximum of twenty visits per member per calendar year
Naturopathy	\$20 copayment; up to a maximum of three visits per member per medical diagnosis per calendar year without prior authorization. Additional visits are covered with prior authorization.
Neurodevelopmental therapy	Inpatient: 90%; up to 60 days per calendar year Outpatient: \$20 copayment for visits with primary care providers; \$40 copayment for visits with specialists; up to 60 visits per calendar year
Nutritional services	90%
Obesity-related surgery	Inpatient: 90% Outpatient: \$20 copayment for visits with primary care providers; \$40 copayment for visits with specialists
Out-of-area travel benefit	Prescription drugs and medical services obtained outside the Group Health service area are covered up to \$2,000 per member per calendar year
Skilled nursing facility	90%; up to 60 days per member per calendar year at a skilled nursing facility
Temporomandibular joint (TMJ) dysfunction	Inpatient: 90% Outpatient: \$20 copayment for visits with primary care providers; \$40 copayment for visits with specialists
Tobacco cessation	100%
Transplants	Inpatient: 90% Outpatient: \$20 copayment for visits with primary care providers; \$40 copayment for visits with specialists

Specialized benefits	
Microsoft provides these unique benefits to you through the Group Health Cooperative HMO Plan.	
Benefit	Coverage
Autism/Applied behavior analysis (ABA) therapy	90%
Transgender services	\$20 copayment for visits with primary care providers; \$40 copayment for visits with specialists; \$100 copay for outpatient hospital care
Weight management program	80% up to a maximum lifetime benefit of \$6,000

Plan benefits



The following pages provide details on the plan's benefits. The plan's [Exclusions and limitations](#), including the requirement of medical necessity, apply to these benefits.

Acupuncture

\$20 copayment; up to eight visits per member per diagnosis per calendar year without prior authorization.

Additional visits are covered when prior authorized. Members may make appointments without prior authorization with Group Health-contracted providers. Visit limit does not apply for treatment for Chemical Dependency.

Related laboratory and radiology services are covered only when obtained through a Group Health facility under the [laboratory and radiology](#) benefit.

Additional exclusions and limitations for acupuncture

In addition to the plan's [Exclusions and limitations](#), the following services and supplies are excluded from this benefit:

- Herbal supplements
- Services not within the scope of the practitioner's licensure

Ambulance

Plan pays 90%

Coverage includes licensed surface (ground or water) and air ambulance transportation to the nearest medical facility equipped to treat the member's condition, when any other mode of transportation would endanger the member's health or safety. This benefit is limited to the member that requires transportation.

Benefits are also provided at 100% for transportation from hospital-to-hospital, as medically necessary for the member's care when approved by Group Health.

Autism/Applied Behavior Analysis (ABA) therapy

Plan pays 90%

This benefit covers behavioral interventions based on the principles of Applied Behavioral Analysis (ABA) through eligible providers.

Who is eligible

This benefit will be available to dependent children age two and older covered by Group Health, whose primary diagnosis is the following:

- Autistic Disorder (International Classification of Diseases, 9th Revision, Clinical Modification)
- Childhood Disintegrative Disorder
- Asperger's Disorder

- Rett's Disorder and Pervasive Development Disorder Not Otherwise Specified/Atypical Autism
- Pervasive Developmental Disorder



- If you need assistance confirming the diagnosis your doctor provides is an eligible diagnosis for the Autism/Applied Behavioral Analysis benefit you may contact Group Health Customer Service Center at (206) 901-4636.

Eligible providers

The benefit covers services through providers who have met established qualifications for certification (known as certified providers) and who perform services in consultation with a certified provider (known as therapy assistants).



- Call (206) 901-4636 or (888) 901-4636 or visit Group Health Cooperative online for a list of approved Certified Autism Providers (not including Therapy Assistants) eligible for reimbursement under this benefit, to receive a copy of the certification criteria, or for an application for providers not currently on the list.

For the purpose of this benefit only, services of a certified provider will be covered even if the provider does not meet the plan's requirements as an eligible provider under the [rehabilitative services](#) or [mental health and substance abuse](#) benefit.

Covered services

Services must be ordered by the dependent's treating physician to be covered. An approved certified provider acts as the program manager for the member. Benefits are available for time used to evaluate the member and document findings and progress reports, and to create and update treatment plans; and time used to train and evaluate the work of the therapy assistants working directly with the member to implement the treatment plan. Therapy Assistant services that are provided by a Program Manager will be paid at the Therapy Assistant rate.

In most cases, therapy assistants will provide the implementation portion of the treatment plan. Therapy assistant time is eligible for face-to-face time with the member to perform the tasks described in the treatment plan and to document outcomes; and time to meet with the program manager for training and to discuss treatment plan issues. Therapy Assistant services that are provided by a Program Manager will be paid at the Therapy Assistant rate.

Claims for ABA services should clearly list the level of service (certified provider/program manager; or therapy assistant), the date the service was provided, the time the service started and ended, the hourly charge for the service, and the total charge for that service.

ABA services are not covered for the following:

- Babysitting or doing household chores
- Time spent under the care of any other professional
- Travel time
- Home schooling in academics or other academic tutoring

Benefit coverage above the allowable amount

You may be billed for charges assessed above the allowable amount from providers who have not agreed to offer discounts to members covered by this plan. Any amounts you pay for charges in excess of allowable charges will not count towards satisfying any deductible requirements, or out-of-pocket maximums that may apply to other benefits provided through this plan.



An **allowable charge** is the level of benefits that are payable by Group Health when expenses are incurred from a network provider. Expenses are considered an allowed amount if the charges are consistent with those normally charged to others by the provider or organization for the same services or supplies; and the charges are within the general range of charges made by other providers in the same geographical area for the same services or supplies. Members shall be required to pay any difference between the network provider's charge for services and the allowed amount.

Prior Authorization

Prior authorization, also referred to as a pre-service review, is recommended to determine coverage is available before the service occurs. Either the member or the provider may contact Group Health for prior authorization.



Prior authorization is an advance determination by Group Health that the service is medically necessary and that the member's plan has benefits available for the service being requested. This determination is offered in certain situations where medical records must be provided to establish medical necessity before the plan will pay for the service. Services are subject to eligibility and benefits at the time of service.

Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition based on national, evidence-based guidelines. Group Health and Microsoft reserve the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

For ABA/Autism benefits, the prior authorization requires the following documents:

- The dependent's treating physician's order for ABA services
- The clinical documentation of the qualifying diagnosis
- The Plan of Treatment created by the approved Program Manager

Group Health will issue a prior authorization that will provide services for a six-month period of time. The prior authorization process and subsequent clinical review includes the following steps:

The following is the process for a prior authorization for the autism/ABA therapy benefit and subsequent clinical review:

1. The dependent's treating physician or specialist diagnoses the child with an Autism Spectrum Disorder (Autistic Disorder, Childhood Disintegrative Disorder, Rett's Disorder, Pervasive Developmental Disorder Not otherwise Specified, and Asperger's Disorder) and refers the child for ABA treatment.

2. An initial evaluation is performed by the approved certified provider to determine if the child is a candidate for an ABA and/or related structured behavioral program. If the child is determined to be a candidate by the evaluating approved certified provider, the approved certified provider would create and submit a treatment plan including type and frequency of services planned for the immediate six-month period. The approved certified provider must send the treatment plan to Group Health so that eligibility for services can be determined.
3. Every six months, the approved certified provider who is overseeing the treatment must submit an updated treatment plan to Group Health. The approved certified provider must determine that the treatment plan and services being provided are in accordance with ABA guidelines. If any substantial change in the frequency or type of program is necessary during the six-month treatment time, a revised Treatment Plan should be submitted to Group Health for notification of the revision of the treatment plan.
4. Progress reports should be created at least monthly by the certified provider to include documentation of the therapy assistant interventions and/or their own interventions with the member and a written summary of the child's progress. If the child has not made progress in the last six months, the updated treatment plan should reflect a change in approach. Progress reports should be available to Group Health upon request.

Services for this treatment that do not meet criteria described in the program are subject to retrospective denial of benefits. Claims for these services must be accompanied by a completed Autism/ABA Therapy Services Billing Summary signed by the certified provider and the child's parent.

Additional exclusions and limitations for autism/ABA therapy

In addition to the plan's [Exclusions and limitations](#), the following services and supplies are excluded from this benefit:

- This benefit is not provided for rehabilitative services (which apply under the [rehabilitation](#) services benefit) or mental health services (which apply under the [mental health and substance abuse](#) benefit).
- Benefits for services provided by volunteers, childcare providers, or family members, and benefits paid for by state, local, and Federal agencies will not be covered. Volunteer services or services provided by a family member of the child receiving the services by or through a school, books, and other training aids will also not be covered.
- Other unspecified developmental disorders or delays, or any other delay or disorder in a child's motor, speech, cognitive, or social development are not covered under this benefit
- This benefit covers only the allowable fees for eligible services performed by the approved certified provider and those providing interventions based on principles of ABA and/or related structured behavioral programs under the supervision of the approved certified provider. Other expenses associated with providing the treatment, such as the tuition, program fees, travel, meals, and lodging of the approved certified provider and expenses of those working under the approved certified provider's supervision, the dependent, and his or her family members will not be covered.

Cardiac rehabilitation

Outpatient: \$20 copayment for primary care providers; \$40 copayment for specialists

Cardiac rehabilitation is covered up to a total of 36 visits per cardiac event when clinical criteria is met. Prior authorization is required.

Chemical dependency

Inpatient: Plan pays 90%

Outpatient: \$20 copayment for primary care providers; \$40 copayment for specialists; \$100 copayment for outpatient hospital care

Inpatient services

Residential treatment services are provided in a facility specifically licensed in the state where it practices as a residential treatment center. Residential treatment services require prior authorization.



Residential treatment centers or services offer facility-based treatment providing active treatment in a controlled environment. At least weekly physician visits are required and services must offer treatment by a multi-disciplinary team of licensed professionals.

Outpatient services

All alcoholism and/or drug abuse treatment services must be:

- Provided at a Group Health facility or Group Health-approved treatment facility
- Deemed medically necessary; the following services are covered on an inpatient or outpatient basis: inpatient residential treatment services, diagnostic evaluation and education, organized individual and group counseling, and/or prescription drugs and medicines
- Court-ordered treatment is covered only if determined to be medically necessary



Chemical dependency means an illness characterized by physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverages, and where the member's health is substantially impaired or endangered or his or her social or economic function is substantially disrupted.

Additional exclusions and limitations for chemical dependency

In addition to the plan's [Exclusions and limitations](#), the following services and supplies are excluded from this benefit:

- Experimental or investigational therapies, such as wilderness therapy;
- Facilities and treatment programs which are not certified by the Department of Social Health Services or which are not listed in the Directory of Certified Chemical Dependency Services in Washington State

Circumcision

Inpatient: Plan pays 90%

Outpatient: \$20 copayment for primary care providers; \$40 copayment for specialists; \$100 copayment for outpatient hospital care

Devices, equipment, and supplies (Durable Medical Supplies)

Plan pays 90%

The following services are covered:

- **Orthopedic Appliances:** Orthopedic appliances that are attached to an impaired body segment for the purpose of protecting the segment or assisting in restoration/improvement of its function. Excluded appliances include arch supports such as custom shoe modifications, inserts and their fitting; orthopedic shoes that are not attached to an appliance. Therapeutic shoes, modifications, shoe inserts for severe diabetic foot disease are not excluded.
- **Durable Medical Equipment:** Equipment which can withstand repeated use, is primarily and customarily used to serve a medical purpose, is useful only in the presence of an illness or injury, and is used in the member's home. Durable medical equipment includes: hospital beds, wheelchairs, walkers, crutches, canes, glucose monitors, external insulin pumps, oxygen and oxygen equipment.
- **Prosthetic Devices:** Prosthetic devices are items that replace all or part of an external body part, or function thereof
- **Ostomy Supplies:** Ostomy supplies for the removal of bodily secretions or waste through an artificial opening
- **Post-mastectomy bras/forms:** Post-mastectomy bras are limited to two every six months (replacements within this 6-month period are covered when medically necessary due to a change in the member's condition)

Prior authorization is required for devices, equipment and supplies including repair, adjustment or replacement of appliances and equipment.

Additional exclusions and limitations for devices, equipment, and supplies

In addition to the plan's [Exclusions and limitations](#), the following services and supplies are excluded from this benefit:

- Take-home dressings and supplies following hospitalization
- Other supplies, dressings, appliances and devices not specifically listed as covered above
- Replacement or repair of appliances, devices, and supplies due to loss, theft, breakage from willful damage, neglect, wrongful use, or personal preference
- Structural modifications to a member's home or personal vehicle
- Wigs/hair prosthesis



Group Health will determine if equipment is made available on a rental or purchase basis.

Detoxification services for alcoholism and drug abuse

Inpatient: Plan pays 90%

Outpatient: \$75 copayment for emergency facility (waived if admitted)

Benefits are provided for withdrawal of alcohol and/or drugs from a member for whom consequences of abstinence are so severe that they require medical or nursing assistance in a hospital setting, which is needed immediately to prevent serious impairment to the member's health. Chemical withdrawal (detoxification) is provided without prior authorization.

The member must notify Group Health via the notification line at 888-457-9516 within 24 hours following inpatient admission, or as soon as medically possible. If a member is hospitalized in a non-Group Health facility or program, Group Health reserves the right to require transfer of the member to a Group Health facility or program upon consultation between a Group Health provider and the attending physician. If the member

refuses transfer to a Group Health facility or program, all further costs incurred during the hospitalization are the responsibility of the member.

Diabetic needs and supplies

Insulin, needles, syringes, test strips and lancets covered under the [prescription drug](#) benefit.

90% for external insulin pumps, blood glucose monitors, and related supplies covered under the [devices, equipment, and supplies](#) benefit.

100% for diabetic retinal screening.

Dialysis (Home and Outpatient)

Outpatient: \$20 copayment for primary care providers; \$40 copayment for specialists; \$100 copayment for outpatient hospital care

Dialysis in an outpatient or home setting is covered for members with end-stage renal disease (ESRD)

Dialysis requires prior authorization

Emergency care

Group Health Facility: \$75 copayment (waived if admitted)

Non-Group Health Facility: \$75 copayment (waived if admitted), plus the difference between the non-Group Health facility's charge and the Group Health allowable charge.



An **allowable charge** is the negotiated amount that Group Health providers have agreed to accept as payment in full for a covered service. Out-of-network providers may not accept the allowable charge as payment in full. You are responsible for paying the difference between the allowable charge and the amount your out-of-network provider charges.

At non-Group Health facilities, the plan covers the allowable charge provided you:

- Pay the emergency services copayment
- Notify Group Health at (888) 457-9516 within 24 hours following inpatient admission, or as soon as medically possible

Emergency services include professional services, treatment and supplies, facility costs, outpatient charges for patient observation and medical screening exams required to stabilize a patient.

If the member is admitted to a Group Health facility directly from the emergency room, the emergency services copayment is waived. Inpatient hospital care will be covered at 90%. Please see the [hospital care](#) benefit for more information.

If a member is hospitalized in a non-Group Health facility, Group Health reserves the right to require transfer of the member to a Group Health facility, upon consultation between a Group Health provider and the attending physician. If the member refuses to transfer to a Group Health facility, all further costs incurred during the hospitalization are the responsibility of the member.

Care that is a direct result of the emergency must be obtained from Group Health providers, unless a Group Health provider has previously authorized such follow-up care from a non-Group Health provider.



Urgent care received at any hospital emergency department is not covered unless prior authorization is received by a Group Health provider. Please see the [urgent care](#) benefit for more information.

Growth hormone

90% under the [prescription drugs](#) benefit

This benefit covers growth hormones for treatment of growth disorders.

Hearing care and hardware

\$20 copayment for primary care providers; \$40 copayment for specialists

Cochlear implants when Group Health criteria is met. Hearing exams for hearing loss and evaluation and diagnostic testing for cochlear implants only when provided at Group Health-approved facilities.

Covered for cochlear implants including implant surgery, pre-implant testing, post-implant follow-up, speech therapy, programming and associated supplies (such as transmitter cable, and batteries).

Hearing hardware

Plan pays 90% up to a maximum benefit of \$3,000 per member in a period of three consecutive calendar years.

Home health care

Plan pays 100% with no visit limit

Home health care services are covered when services are received from Group Health providers for members who meet the following criteria:

- The member is unable to leave home due to his or her health problem or illness (unwillingness to travel and/or arrangements for transportation do not constitute inability to leave the home).
- The member requires intermittent skilled home health care services.
- A Group Health provider has determined that such services are medically necessary and are most appropriately rendered in the member's home.



Skilled home health care includes reasonable and necessary care for treatment of an illness or injury that requires the skill of a nurse or therapist—based on the complexity of the service and the condition of the member. Services are performed directly by an appropriately licensed professional provider.

Covered services for home health care include the following services on an intermittent basis:

- Nursing care
- Restorative physical therapy
- Restorative occupational therapy, restorative respiratory therapy
- Restorative speech therapy
- Durable medical equipment
- Medical social worker
- Limited home health aide services

Home health care services require prior authorization

Additional exclusions and limitations for home health care

In addition to the plan's Exclusions and limitations, the following services and supplies are excluded from this benefit:

- Private duty nursing
- Housekeeping or meal services
- Any care provided by or for a member of the member's family
- Any other services rendered in the home that do not meet the definition of skilled home health care (such as custodial care) or are not specifically listed as covered under this plan

Hospice care

Plan pays 100%; up to five consecutive days per occurrence

- Hospice care is covered when provided by a licensed hospice care program. This program uses an interdisciplinary team of personnel to provide comfort and supportive services to a member and any family members who are caring for the member, who is experiencing a life-threatening disease with a limited prognosis. These services include acute, respite and home care to meet the physical, psychosocial and special needs of the member and their family during the final stages of illness. In order to qualify for hospice care, the member's provider must certify that the member is terminally ill and is eligible for hospice services.



Hospice care means a coordinated program of home and inpatient care, available 24 hours a day.

Respite care means continuing to provide care in the temporary absence of the member's primary caregiver or caregivers.

Inpatient hospice services

Short-term care for inpatient hospice services shall be covered when preauthorized. Respite care is covered for a maximum of five consecutive days per occurrence.

Other covered hospice services, when billed by a licensed hospice program, include:

- Inpatient and outpatient services and supplies for injury and illness
- Semi-private room and board, except when a private room is determined to be necessary
- Durable medical equipment when billed by a licensed hospice care program

Hospice care requires prior authorization.

Additional exclusions and limitations for hospice care

In addition to the plan's [Exclusions and limitations](#), the following services and supplies are excluded from this benefit:

- Private duty nursing
- Financial or legal counseling services
- Meal services

- Any services provided by family members

Hospital care

Inpatient: Plan pays 90% for inpatient medical and surgical services

Outpatient: \$100 copayment for outpatient hospital surgery including ambulatory surgical centers

Inpatient services

Inpatient services include:

- Room and board (including private room when prescribed) and general nursing services
- Hospital services (including use of operating room, anesthesia, oxygen, X-ray, laboratory, and radiotherapy services)
- Drugs and medications administered during confinement
- Medical implants
- Acute chemical withdrawal (detoxification)

Alternative care arrangements may be covered as a cost-effective alternative instead of otherwise covered medically necessary hospitalization or other institutional care with the consent of the member and recommendation from the attending physician or licensed health care provider. Alternative care arrangements must be determined to be appropriate and medically necessary based upon the member's medical condition. Such care is covered to the same extent the replaced hospital care is covered. Alternative care arrangements also require prior authorization.

Members are required to notify Group Health by way of the Group Health notification line at 888-457-9516 within 24 hours following any admission, or as soon as medically possible, upon receiving any of the following non-scheduled services:

- Acute chemical withdrawal (detoxification) services
- Emergency psychiatric services
- Labor and delivery
- Inpatient admissions needed for treatment of urgent conditions that cannot reasonably be delayed until prior authorization can be obtained

Non-emergency inpatient hospital services require prior authorization, which will be initiated with Group Health by your provider.

Additional exclusions and limitations for hospital care

In addition to the plan's [Exclusions and limitations](#), the dressings and supplies following hospitalization are excluded from this benefit, as are internally implanted insulin pumps, artificial hearts, artificial larynx and any other implantable device that has not been approved by Group Health's medical director.



Call the Group Health notification line at (888) 457-9516 within 24 hours of any admission or nonscheduled services.

Infusion therapy

\$20 copayment for primary care providers; \$40 copayment for specialists

This benefit covers medically necessary infusion therapy such as antibiotics, hydration, chemotherapy and pain management.

Plan pays 100% for associated infused medications.

Laboratory and radiology

Plan pays 100%

This benefit covers nuclear medicine, radiology, ultrasound and laboratory tests, including high end radiology imaging services such as CAT scan, MRI and PET which are subject to prior authorization except when associated with Emergency services or inpatient.

Services received as part of an emergency visit are covered as Emergency Services.

Preventive laboratory and radiology services are covered in accordance with the well care schedule established by Group Health and the Patient Protection and Affordable Care Act of 2010. The well care schedule is available in Group Health medical centers, at www.ghc.org, or upon request from Customer Service.

Manipulative (chiropractic) therapy

\$20 copayment; up to twenty visits per member per calendar year

This benefit covers visits for manipulative therapy of the spine and extremities when Group Health clinical criteria are met.

Additional exclusions and limitations for manipulative therapy

In addition to the plan's [Exclusions and limitations](#), the following services and supplies are excluded from this benefit:

- Supportive care primarily to maintain the level of correction already achieved
- Care primarily for the convenience of the member
- Care on a non-acute, asymptomatic basis
- Charges for any other services that do not meet Group Health's clinical criteria as medically necessary

Maternity and pregnancy care

Inpatient: Plan pays 90%

Outpatient: Plan pays 100% for routine prenatal and postpartum visits; \$20 copayment for primary care providers; \$40 copayment for specialists for non-routine maternity care, including care for complications or termination of pregnancy.

Coverage includes complications of pregnancy, in-utero treatment for the fetus and prenatal and postpartum care for all female members including dependent daughters. Preventive services related to preconception, prenatal and postpartum care are covered as Preventive Services including prenatal testing for the detection of congenital and heritable disorders, when medically necessary, as determined by Group Health's medical director and in accordance with Board of Health standards for screening and diagnostic tests during pregnancy. Home births are considered outpatient services.

The member's physician, in consultation with the member, will determine the member's length of inpatient stay following delivery. Treatment for post-partum depression or psychosis is covered only under the [mental health](#) benefit.

Additional exclusions and limitations for maternity and pregnancy care

In addition to the plan's [Exclusions and limitations](#), the following services and supplies are excluded from this benefit:

- Birthing tubs
- Genetic testing of non-members
- Fetal ultrasound in the absence of medical indications

Mental health and substance abuse

Inpatient: Plan pays 90%

Outpatient: 100%, up to calendar year visit limits through Microsoft CARES employee assistance program, then \$20 copayment for primary care providers; \$40 copayment for specialists



To access these benefits, you must contact the Group Health Behavioral Health Unit at (888) 287-2680 or (206) 901-6300.

Inpatient care

Benefits include coverage for acute treatment and stabilization of psychiatric emergencies in Group Health-approved hospitals. Coverage for services incurred at non-Group Health facilities exclude any charges that would otherwise be excluded for hospitalization within a Group Health facility.

Services provided under involuntary commitment statutes must be provided at facilities approved by Group Health. Services for any involuntary court-ordered treatment program can be covered—only if determined to be medically necessary by Group Health's medical director.

Coverage for voluntary or involuntary emergency inpatient psychiatric services is subject to the emergency care benefit under [Emergency services](#) section, including the 24-hour notification and transfer provisions.

Outpatient care

This benefit covers outpatient care after the [Microsoft CARES employee assistance program](#) benefits are exhausted.

Type of outpatient care	You will be covered as follows
Through the Microsoft CARES employee assistance program (EAP) as administered by Wellspring Family Services	<ul style="list-style-type: none"> • 100% of eligible charges up to calendar year visit limits • Three visits per member for individual counseling • Three telephonic counseling sessions per member for individual counseling • Eight visits per family for family or married/domestic partner couples counseling <p>A visit includes each attendance of the provider to the member, regardless of the type of professional services rendered, and whether it might otherwise be termed consultation, treatment, or described in some other manner. For benefit calculation purposes, a typical mental health visit is considered one hour.</p>
Over and above the EAP benefit or from a non-EAP provider	<ul style="list-style-type: none"> • \$20 copayment for primary care providers • \$40 copayment for specialists

Mental health services provide the most clinically appropriate and medically necessary level of mental health care intervention as determined by Group Health's medical director. Treatment may use psychiatric, psychological, and/or psychotherapy services to achieve these objectives.

Mental health services including medical management and prescriptions are covered the same as for any other condition. Prescriptions are covered under the [prescription drugs](#) benefit.

Additional exclusions and limitations for mental health and substance abuse

In addition to the plan's Exclusions and limitations, the following services and supplies are excluded from this benefit:

- Covered services are limited to those services authorized by Group Health's medical director for covered clinical conditions for which the reduction or removal of acute clinical symptoms or stabilization can be expected, given the most clinically appropriate level of mental health care intervention
- Academic or career counseling and personal growth or relationship enhancement
- Assessment and treatment services that are primarily vocational and academic
- Court-ordered or forensic treatment not considered medically necessary, including reports and summaries
- Work- or school-ordered assessment and treatment not considered medically necessary
- Counseling for overeating not considered medically necessary
- Specialty treatment programs such as "behavior modification programs" not considered medically necessary
- Relationship counseling or phase-of-life problems (V-code only diagnoses)
- Custodial care
- Any other services not specifically listed as covered in this section
- All other provisions, exclusions, and limitations under this plan also apply

Naturopathy

\$20 copayment; up to three visits per member per medical diagnosis per calendar year without prior authorization

Additional visits are covered with prior authorization. Related laboratory and radiology services are covered only when obtained through a Group Health facility under the [laboratory and radiology](#) benefit.

Additional exclusions and limitations for naturopathy

In addition to the plan's [Exclusions and limitations](#), herbal supplements, nutritional supplements, and any services not within the scope of the practitioner's licensure are excluded from this benefit.

Neurodevelopmental therapy

Inpatient: Plan pays 90%

Outpatient: \$20 copayment for primary care providers; \$40 copayment for specialists

Limit: up to 60 days/visits per calendar year (combined with the [rehabilitation benefit](#))

Covered services include: physical therapy, occupational therapy, and speech therapy services for the restoration and improvement of function for neurodevelopmentally disabled members. Coverage also includes maintenance of a covered member in cases where significant deterioration in the member's condition would result without the services.

Additional exclusions and limitations for neurodevelopmental therapy

In addition to the plan's [Exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- All services must be provided at a Group Health facility or a Group Health-approved rehabilitation facility and outpatient services require a prescription or order from a physician that reflects a written plan of care to restore function, and must be provided by a rehabilitation team that includes a physician, nurse, physical therapist, occupational therapist, massage therapist, or speech therapist
- Services are limited to those necessary to restore or improve functional abilities when physical, sensori-perceptual and/or communication impairment exists due to injury, illness, or surgery
- Specialty treatment programs
- Inpatient residential treatment services
- Specialty rehabilitation programs including "behavior modification programs"
- Therapy for degenerative or static conditions when the expected outcome is primarily to maintain the member's level of functioning (except as set forth in this section for treatment of neurodevelopmental conditions)
- Recreational life-enhancing relaxation or palliative therapy
- Implementation of home maintenance programs
- Any services not specifically included as covered in this section
- Any services that are excluded by the plan

Nutritional services

Plan pays 90%

Covered services include parenteral nutritional therapy, elemental formulas for malabsorption (and an eosinophilic gastrointestinal disorder), and dietary formula for the treatment of phenylketonuria. Necessary equipment and supplies covered under the [devices, equipment, and supplies benefit](#).

Additional exclusions and limitations for nutritional services

In addition to the plan's [Exclusions and limitations](#), this benefit excludes any other of the following:

- Dietary formulas or medical foods
- Oral nutritional supplements
- Special diets
- Prepared foods/meals

Obesity-related surgery

Inpatient: Plan pays 90%

Outpatient: \$20 copayment for primary care providers; \$40 copayment for specialists

Coverage includes bariatric surgery and related hospitalizations when Group Health criteria are met. Obesity related services require prior authorization. Weight-loss programs, medications, and related physician visits for medication monitoring are not covered, except those covered under the [weight management](#) benefit.

Additional exclusions and limitations for obesity-related surgery

In addition to the plan's [Exclusions and limitations](#), the following services and supplies are excluded from this benefit:

- Pre- and post-surgical nutritional counseling and related weight-loss programs
- Prescribing and monitoring of drugs
- Structured weight-loss and/or exercise programs for any reason
- Specialized nutritional counseling

Out-of-area travel benefit

Plan pays 100%; up to a maximum of \$2,000 per member per calendar year

All applicable cost shares, contract provisions, limitations and exclusions apply the same as if services were covered within Group Health's service area.

Members may be asked to pay the provider at the time services are received. If the services are covered under this benefit, you will be reimbursed the reasonable charges for the care up to the maximum amount.

Submit a claim to Group Health for the services on a [Medical & Prescription Drug Claim\(s\) Form](#) for Member Reimbursement. Submit the form with all necessary supporting documentation (i.e., itemized bills and receipts, explanation of the services, and the identification information from your ID card).



Send claims to:

Group Health, Claims Administration
P.O. Box 34585
Seattle, WA 98124-1585

Plastic and reconstructive services

Inpatient: Plan pays 90%

Outpatient: \$20 copayment for primary care providers; \$40 copayment for specialists; \$100 copayment for outpatient hospital care

Covered services include:

- Correction of a congenital disease or congenital anomaly.
- Correction of a medical condition following an injury or resulting from surgery that has produced a major effect on the member's appearance. The service must, in the opinion of a Group Health provider, reasonably correct the condition.
- Reconstructive surgery and associated procedures, including internal breast prostheses, following a mastectomy, regardless of when the mastectomy was performed
- Members will be covered for all stages of reconstruction on the non-diseased breast produce a symmetrical appearance
- Complications of covered mastectomy services, including lymphedemas, are covered

Plastic and reconstructive surgery requires prior authorization.



A **congenital anomaly** is a marked difference from the normal structure of a body part that is physically evident from birth.

Additional exclusions and limitations for plastic and reconstructive services

In addition to the plan's [Exclusions and limitations](#), the following services and supplies are excluded from this benefit:

- Cosmetic services and surgery
- Treatment for complications resulting from cosmetic surgery
- Complications of non-covered services

Podiatric services

\$20 copayment for primary care providers; \$40 copayment for specialists

Routine foot care is covered when such care is directly related to the treatment of diabetes and, when approved by Group Health's medical director, other clinical conditions that effect sensation and circulation to the feet.

Additional exclusions and limitations for podiatric services

In addition to the plan's [Exclusions and limitations](#), the following services and supplies are excluded from this benefit: all other routine foot care.

Prescription drugs

This benefit covers all FDA-approved, medically necessary prescription drugs, when prescribed for the member's use outside of a medical facility and dispensed by a licensed pharmacist in a pharmacy licensed by the state in which the pharmacy is located.

All drugs, supplies and devices must be obtained at a Group Health-designated pharmacy except for drugs dispensed for emergency services or for emergency services obtained outside of the Group Health service area. Information regarding Group Health-designated pharmacies is reflected in the Group Health Provider Directory available at www.ghc.org or can be obtained by contacting the Group Health Customer Service Center at (206) 901-4636.

Prescription drug Cost Shares are payable at the time of delivery. Certain brand name insulin drugs are covered at the generic drug Cost Share. Preferred contraceptive drugs as recommended by the U.S. Preventive Services Task Force (USPSTF) are covered as Preventive Services.

Certain drugs are subject to prior authorization as shown in the [Preferred drug list](#) (formulary).

Certain maintenance drugs will be covered at 100% under the [preventive care benefit](#).

Prescription drug copayments

Type of prescription (30-day supply)	Group Health pharmacy copayment	Group Health mail order copayment
Value-based	\$0	\$0
Preferred Generic	\$10	\$5
Preferred Brand	\$25	\$20
Non-Preferred generic and brand (when prescribed by Group Health provider)	\$50	\$45



A **prescription drug** is any medical substance that cannot be dispensed without a prescription according to federal law. Only medically necessary prescription drugs are covered by this plan.

Value-based drugs are drugs for chronic disease management such as diabetes, hyperlipidemia, heart failure and hypertension that are considered high value and are covered on a lower cost share tier.

Preferred generic drugs are equivalent to brand-name drugs but are available at a lower cost because the patent has expired.

Preferred brand-name drugs are sold under a trademark name. An equivalent generic drug may or may not be available at lower cost, depending upon whether the patent on the brand-name drug has expired.

The **preferred drug list** is the list of prescription drugs that are covered under the Group Health HMO Plan.



Call (206) 901-4636 or (888) 901-4636 or visit [Group Health Cooperative](#) online to review the preferred drug list.



You will be charged, under the benefit, for replacing lost or stolen prescription drugs, or devices.

Covered drugs

This benefit covers:

- Prescription drugs, including preferred generic, preferred brand, and non-preferred (if prescribed by a Group Health provider)
- Supplies, and devices, including diabetic supplies (insulin, needles, syringes, test strips and lancets)
- Prescription drugs, including medications and injections, for anticipated illness while traveling
- Routine costs for prescription medications provided in a clinical trial. "Routine costs" means items and services delivered to the member that are consistent with and typically covered by the plan or coverage for a member who is not enrolled in a clinical trial.

The Group Health Preferred drug list is a list of prescription drugs, supplies, and devices considered to have acceptable efficacy, safety and cost-effectiveness. The Preferred drug list is maintained by a committee consisting of a group of physicians, pharmacists and a consumer representative who review the scientific evidence of these products and determine the Preferred and Non-Preferred status as well as utilization management requirements. Preferred drugs generally have better scientific evidence for safety and effectiveness and are more affordable than Non-Preferred drugs. The preferred drug list is available at www.ghc.org, or upon request from Customer Service.

Members may request a coverage determination by contacting Customer Service. Coverage determination reviews may include requests to cover non-preferred drugs, obtain prior authorization for a specific drug, or exceptions to other utilization management requirements, such as quantity limits. If coverage of a non-Preferred drug is approved, the drug will be covered at the Preferred drug level.

Prescription drugs have been approved by the Food and Drug Administration (FDA) and can, under Federal or state law, be dispensed only pursuant to a prescription order. These drugs include off-label use of FDA-approved drugs, provided that such use is:

- Documented to be effective in one of the standard reference compendia
- Shown by a majority of well-designed clinical trials published in peer-reviewed medical literature to provide improved efficacy or safety of the agent in comparison to standard therapies (or over placebo if no standard therapies exist)
- Approved by the Federal Secretary of Health and Human Services

If a Member has a new prescription for a chronic condition, the Member may request a coordination of medications so that medications for chronic conditions are refilled on the same schedule (synchronized). Cost-shares for the initial fill of the medication will be adjusted if the fill is less than the standard quantity.

Specialty drugs are high-cost drugs prescribed by a physician that requires close supervision and monitoring for serious and/or complex conditions, such as rheumatoid arthritis, hepatitis or multiple sclerosis. Specialty drugs must be obtained through Group Health's preferred specialty pharmacy vendor and/or network of specialty pharmacies. For a list of specialty drugs or more information about Group Health's specialty pharmacy network, please go to the Group Health website at www.ghc.org or contact Customer Service at (206) 901-6924 or toll-free at (800) 290-8900.



Standard reference compendia refers to the American Hospital Formulary Service—Drug Information; the American Medical Association Drug Evaluation; the United States Pharmacopoeia—Drug Information, or other authoritative compendia as identified from time to time by the Federal Secretary of Health and Human Services. "Peer-reviewed medical literature" means scientific studies printed in health care journals or other publications in which original manuscripts are published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts. Peer-reviewed medical literature does not include in-house publications of pharmaceutical manufacturing companies.

Medicare Part D coverage

This benefit is equal to or greater than the Medicare Part D prescription drug benefit. Eligible members who are also eligible for Medicare Part D pharmacy benefits can remain covered under the plan and not be subject to Medicare-imposed late enrollment penalties should they decide to enroll in a Medicare Part D pharmacy plan at a later date; however, the member could be subject to payment of higher Part D premiums if the member subsequently has a break in creditable coverage of 63 continuous days or longer before enrolling in a Part D plan.



For more information about prescription drug policies or benefits, call (206) 901-4636 or (888) 901-4636 or visit Group Health Cooperative online.

Additional exclusions and limitations for prescription drugs

In addition to the plan's [Exclusions and limitations](#), the following services and supplies are excluded from this benefit:

- Drugs and injectables, except as described in this summary
- Over-the-counter drugs (including prescription drugs that have an over-the-counter equivalent), supplies and devices not requiring a prescription under state law or regulation, including most prescription vitamins, except as recommended by the U.S. Preventive Services Task Force (USPSTF)
- Drugs used in the treatment of sexual dysfunction disorders
- Compounds which include a non-FDA approved drug
- Growth hormones for idiopathic short stature without growth hormone deficiency
- Administration of drugs and injectables. This exclusion does not apply to drugs and supplements in accordance with the well care schedule established by Group Health and the Patient Protection and Affordable Care Act of 2010.

Preventive care

Plan pays 100% for services detailed in the Group Health well-care schedule and preventive (maintenance) medications

Covered services include, but are not limited to:

- Well-baby care
- Well-child care
- Screening and tests with A and B recommendations by the U.S. Preventive Services Task Force (USPSTF)

- Services, tests and screening contained in the U.S. Health Resources and Services Administration Bright Futures guidelines as set forth by the American Academy of Pediatricians
- Services, tests, screening and supplies recommended in the U.S. Health Resources and Services Administration women's preventive and wellness services guidelines
- Immunizations recommended by the Centers for Disease Control's Advisory Committee on Immunization Practices
- Female sterilization
- FDA-approved contraceptive drugs, devices, including device removal, and counseling
- Preferred over-the-counter contraceptives and drugs as recommended by the USPSTF when obtained with a prescription
- Routine physical exam
- Mammograms (age appropriate)
- Routine prostate screening
- Colorectal cancer screening for members who are age 50 or older or who are under age 50 and at high risk
- Routine bone density screening

Additional preventive services for women include:

- Well-woman visits, including prenatal and postpartum care
- Preferred FDA-approved contraception methods (including sterilization) and counseling
- Breastfeeding supplies
- Human Papillomavirus (HPV) testing
- Screening for gestational diabetes, domestic violence, and sexually-transmitted infections
- Breast cancer preventive medications for asymptomatic women who are at increased risk for breast cancer and at low risk for adverse medication effects

Preventive care for chronic disease management includes treatment plans with regular monitoring, coordination of care between multiple providers and settings, medication management, evidence-based care, quality of care measurement and results, and education and tools for patient self-management support.

Value-based (maintenance) medications include prescriptions for chronic conditions and FDA-approved contraception methods in the Group Health preferred drug list. All preventive drugs, supplies, and devices must be obtained at a Group Health-designated pharmacy.

For a complete list of what is considered preventive care and paid 100% by the plan, see the Preventive Care service list and the Preventive Drug list, or contact Group Health at (206) 901-4636 or (888) 901-4636

Additional exclusions and limitations for preventive care

In addition to the plan's [Exclusions and limitations](#), the following services and supplies are excluded from this benefit

- Physicals for travel
- Health education programs
- Employment
- Insurance or license

- Laboratory services, which are not in accordance with the Group Health well-care schedule, will be subject to cost shares



Review the [Preventive Care Services and Drugs list](#) for a full list of preventive services.

Radiation therapy

\$40 copayment for oncology, radiation therapy, and chemotherapy specialists

Chemotherapy treats cancer with one or more chemotherapeutic agents (drugs) as part of a standardized regimen. Chemotherapy may also be prescribed to treat other conditions. Oral chemotherapy drugs are covered subject to the Prescription Drug cost share.

Radiation therapy is the medical use of ionizing radiation, generally as part of cancer treatment to control or kill malignant cells. Radiation therapy is synergistic with chemotherapy, and has been used before, during, and after chemotherapy in susceptible cancers.

Respiratory therapy

\$20 copayment for primary care providers; \$40 copayment for specialists.

Respiratory therapy is delivered by a respiratory therapist. Respiratory therapists are specialists and educators in cardiology and pulmonology. Respiratory therapists are also advanced-practice clinicians in airway management; establishing and maintaining the airway during management of trauma, intensive care, and may administer anesthesia for surgery or conscious sedation.

Rehabilitation and Habilitative Care

Inpatient: Plan pays 90%

Outpatient: \$20 copayment for primary care providers; \$40 copayment for specialists

Limit: up to 60 days/visits, whichever occurs first, per calendar year (combined with the [Neurodevelopmental therapy](#) benefit)

Rehabilitation services restore function following illness, injury or surgery, limited to the following restorative therapies: physical therapy, occupational therapy, massage therapy, and speech therapy.

Habilitative care, including: occupational therapy, physical therapy, speech therapy is covered when prescribed by a Group Health physician.

Inpatient care

Inpatient care includes restorative physical, occupational, and speech therapy services, as well as massage therapy and services for neurodevelopmentally disabled members.

Outpatient care

Outpatient care includes restorative physical, occupational, and speech therapy services, as well as massage therapy and services for neurodevelopmentally disabled members.

Additional exclusions and limitations for rehabilitation services

In addition to the plan's [Exclusions and limitations](#), services are subject to all terms, conditions, and limitations of this plan, including the following:

- All services must be provided at a Group Health facility or a Group Health-approved rehabilitation facility and outpatient services require a prescription or order from a physician that reflects a written plan of care to restore function, and must be provided by a rehabilitation team that includes a physician, nurse, physical therapist, occupational therapist, massage therapist, or speech therapist
- Services are limited to those necessary to restore or improve functional abilities when physical, sensori-perceptual and/or communication impairment exists due to injury, illness, or surgery
- Specialty treatment programs
- Inpatient Residential Treatment services
- Specialty rehabilitation programs including "behavior modification programs"
- Therapy for degenerative or static conditions when the expected outcome is primarily to maintain the member's level of functioning (except as described for neurodevelopmental therapy)
- Recreational, life-enhancing, relaxation or palliative therapy
- Implementation of home maintenance programs

Skilled nursing facility

Plan pays 90%; up to 60 days per member per calendar year

Skilled nursing care in a skilled nursing facility is covered when full-time skilled nursing care is necessary in the opinion of the attending Group Health provider.

Care may include room and board, general nursing care, drugs, biologicals, supplies, and equipment ordinarily provided or arranged by a skilled nursing facility. Short-term restorative physical therapy, occupational therapy, and speech therapy are also included.

Additional exclusions and limitations for skilled nursing facility

In addition to the plan's [Exclusions and limitations](#), the following services and supplies are excluded from this benefit:

- Personal comfort items such as telephone and television
- Rest cures
- Domiciliary or convalescent care

Sterilization services**Elective Sterilization – Female**

Plan pays 100% for female sterilization procedures, such as tubal ligation.

Elective Sterilization – Male

Inpatient: Plan pays 90%

Outpatient: \$20 copayment for primary care providers; \$40 copayment for specialists; \$100 copayment for outpatient hospital care

Additional exclusions and limitations for sterilization services

In addition to the plan's [Exclusions and limitations](#), procedures and services to reverse sterilization are excluded from this benefit.

Telehealth

Outpatient: \$20 copayment for primary care providers; \$40 copayment for specialists; \$100 copayment for outpatient hospital care

Telehealth (audio and video communication) services between a consulting distant site provider, and the originating site provider, where the member is located. The originating site is in a rural health professional shortage area as defined by the Centers for Medicare and Medicaid Services.

Additional exclusions and limitations for telehealth

In addition to the plan's [Exclusions and limitations](#), telehealth services when the originating site is not a rural health professional shortage area as defined by the Centers for Medicare and Medicaid Services, as well as the site fee from the originating location are excluded from this benefit.

Temporomandibular Joint (TMJ) services

Inpatient: Plan pays 90%

Outpatient: \$20 copayment for primary care providers; \$40 copayment for specialists; \$100 copayment for outpatient hospital care

Covered services

- Medical and surgical services related to hospital charges for the treatment of TMJ disorders. TMJ appliances are covered under Devices, Equipment, and Supplies.
- Orthognathic (jaw) surgery for the treatment of TMJ disorders, radiology services, TMJ specialist services, and fitting/adjustment of splints

Additional exclusions and limitations for Temporomandibular Joint (TMJ) services

In addition to the plan's [Exclusions and limitations](#), the following services and supplies are excluded from this benefit:

- Treatment for cosmetic purposes
- Bite blocks
- Dental services, including orthodontic therapy and braces for any condition
- Severe obstructive sleep apnea

Any hospitalizations related to these exclusions are also excluded.

Tobacco cessation

Plan pays 100%

This benefit covers:

- Individual and group sessions through Group Health-designated tobacco cessation programs
- Tobacco cessation pharmacy products
- Educational materials when provided through Group Health

Transgender services

Inpatient: Plan pays 90%

Outpatient: \$20 copayment for primary care providers; \$40 copayment for specialists; \$100 copayment for outpatient hospital care

This benefit covers medically necessary transgender surgical services, including facility and anesthesia charges related to the surgery.

Coverage of prescription drugs and mental health treatment associated with gender reassignment surgery is available under the [prescription drugs](#) and [mental health](#) benefits.

Who is eligible

Surgical gender reassignment services will be considered medically necessary if all the following criteria are met:

- For all surgical procedures recognized as medically necessary in the most current Standards of Care published by the World Professional Association for Transgender Health (WPATH), other than genital and breast surgery, benefits are available if you are at least 18 years old and diagnosed as having gender identity disorder
- For breast/chest surgery you must meet the above and have one letter of recommendation for surgery from a mental health professional
- You have been an active member in a recognized gender identity treatment program and have successfully lived and worked within the desired gender role full time for at least 12 months.
- You have received recommendations for surgery from two separate mental health professionals, at least one of which includes an extensive report. One Master's degree-level professional is acceptable if the second letter is from a psychiatrist or PhD clinical psychologist.

Transplants

Inpatient: Plan pays 90%

Outpatient: \$20 copayment for primary care providers; \$40 copayment for specialists; \$100 copayment for outpatient hospital care

Transplants include:

- Heart
- Heart-lung
- Single lung
- Double lung

- Kidney
- Pancreas
- Cornea
- Intestinal/multi-visceral
- Bone marrow
- Liver
- Stem cell support (obtained from allogeneic or autologous peripheral blood or marrow) with associated high-dose chemotherapy

Covered services are limited to the following:

- Inpatient and outpatient medical expenses
 - Evaluation testing to determine recipient candidacy
 - Donor matching tests
 - Hospital charges
 - Procurement center fees
 - Professional fees
 - Travel costs for a surgical team, and
 - Excision fees
- Donor costs for a covered organ recipient are limited to
 - Procurement center fees
 - Travel costs for a surgical team
 - Excision fees
- Follow-up services for specialty visits
- Re-hospitalization
- Maintenance medications during an inpatient stay

Additional exclusions and limitations for transplants

In addition to the plan's [Exclusions and limitations](#), the following services and supplies are excluded from this benefit:

- Donor costs to the extent that they are reimbursable by the organ donor's insurance
- Treatment of donor complications
- Living expenses
- Transportation expenses, except as set forth under this plan

Urgent care

Inside Group Health's service area—\$20 copayment for primary care providers; \$40 copayment for specialists

Outside Group Health's service area—\$75 copayment per visit per member, plus the difference between the non-Group Health facility's charge and the Group Health allowable charge

Care for urgent conditions within the Group Health service area is not covered at non-Group Health facilities except for emergency services. These emergency services will be subject to the applicable emergency care

copayment of \$75, plus the difference between the non-Group Health facility's charge and the Group Health allowable charge.



An **allowable charge** is the negotiated amount that Group Health providers have agreed to accept as payment in full for a covered service. Out-of-network providers may not accept the allowable charge as payment in full. You are responsible for paying the difference between the allowable charge and the amount your out-of-network provider charges.

Weight Management program

Plan pays 80%; up to lifetime benefit maximum of \$6,000 (out-of-pocket maximum does not apply)

This benefit provides coverage for comprehensive and clinically based weight management programs for the treatment of obesity.

Who is eligible

Members are eligible for the Weight Management program benefit if they meet the following criteria:

- Diagnosed as obese (commonly Body Mass Index (BMI) greater than or equal to 30), or
- Overweight with a BMI greater than or equal to 27, and diagnosed with two or more of the following conditions:
 - Congestive heart failure
 - Coronary heart disease
 - Depression
 - Diabetes
 - Hyperlipidemia
 - Hypertension

Dependent children are not eligible for this benefit.

Eligible providers

Approved [weight management providers](#) of this benefit must meet eligibility requirements set forth by Microsoft and Premera and be providing services under a weight management program that is contracted for and approved by Premera for this plan.

Approved weight management programs will be those programs that are comprehensive and clinically based. Approved programs must be based on medical oversight and include treatment from professionals in the areas of nutrition, behavioral therapy, and personal training. An approved program must include an initial minimum 10-week period of frequent sessions with the program's physician, personal trainer, dietician, and behavioral therapist. This initial period must be followed by a minimum three-month maintenance period, which includes regular follow-up visits with these program professionals.

The Weight Management program must be contracted for and approved by Premera both at the time the member begins the program and when he or she completes the program. If the program is not approved and contracted for until after the member has started treatment under the program, no part of the cost of the program will be covered under this benefit.



To find an approved provider, review the [Weight Management providers list](#).

Prior Authorization

Prior authorization, also referred to as a pre-service review, is recommended to determine coverage is available before the service occurs. Either the member or the provider may contact Group Health for prior authorization.



Prior authorization is an advance determination by Group Health that the service is medically necessary and that the member's plan has benefits available for the service being requested. This determination is offered in certain situations where medical records must be provided to establish medical necessity before the plan will pay for the service. Services are subject to eligibility and benefits at the time of service.

Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition based on national, evidence-based guidelines. Group Health and Microsoft reserve the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

A [Weight Management Recommendation form](#) or confirmation of your BMI and co-morbid conditions should be submitted to Premera prior to receiving reimbursement from Premera. Your physician's recommendation will confirm you meet the contract criteria required for this benefit to be available.

The following are the steps that must be completed to ensure that your treatment meets the criteria of this benefit:

1. Take the Weight Management Recommendation form to your regular physician
2. An evaluation is performed by your physician to determine if you meet the eligibility requirements set forth above
3. Your physician faxes or mails the Weight Management Recommendation Form to Premera Care Facilitation to confirm that you meet the weight management eligibility requirements and your physician's approval



Your physician can fax this information to (800) 866-4198 or mail it to:

Premera Blue Cross
Attn: Care Facilitation
P.O. 91059
Seattle, WA 98111-9159

4. Premera Blue Cross will review the information submitted and verify the coverage through a prior authorization

Participation in the program should begin within six months of the prior authorization being issued or a new prior authorization will need to be requested.

Claims payment

Final claims payment will be contingent on Premiera receiving all biometric reporting information for the member. Reimbursement for this benefit may occur in one of two ways. The program you attend will select the claims payment method used.

Method 1: Direct reimbursement to member

The provider will bill you directly for services provided. The frequency of billing should be made clear by the provider before you start the program. The weight management provider may collect a deposit from you to initiate your participation in the program.

During the course of the program you can submit an interim weight management billing claim form on a monthly or quarterly basis to Premiera for reimbursement. You may also submit a final weight management final billing claim form at the end of the program.

If your coverage terminates during the time you are participating in an approved program, and you do not elect COBRA, only services rendered up to the date of termination of coverage will be reimbursed.

Method 2: Direct reimbursement to provider

Reimbursement will be made directly to the weight management provider on a monthly or quarterly basis. The weight management provider may collect a deposit from you to initiate your participation in the program, but will bill Premiera on a monthly or quarterly basis for your ongoing participation.

Additional exclusions and limitations for Weight Management program

In addition to the plan's [Exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- Food
- Nutritional supplements (i.e., protein shakes)
- Drugs or surgical procedures to assist in reducing weight or curbing hunger

Exclusions and limitations

General exclusions

In addition to [exclusions associated with specific benefits](#), the following services are not covered:

- Benefits and related services, supplies and drugs that are not medically necessary for the treatment of an illness, injury, or physical disability, that are not specifically listed as covered under the [What the plan covers](#) section, except as required by law
- Follow-up services related to a non-Covered Service, except as required by federal law
- Complications of non-Covered Services
- Cosmetic services, including treatment for complications resulting from cosmetic surgery, except as provided under the [What the plan covers](#) section
- Services for which a claim was not received by Group Health within 12 months of the date of service. Corrected claims and COB claims need to be submitted within 12 months from the original claim submission date.
- Devices, equipment, and supplies, except as specifically stated under the [devices, equipment, and supplies](#) benefit

- Benefits that overlap or duplicate benefits for which the member is eligible under any other group plan, workers' compensation or similar employee benefit law, Medicare Part A or B, or a government-sponsored program of any type
- Those parts of an examination and associated reports and immunizations required for employment, immigration (except for immigration exams authorized by Microsoft and provided by designated immigration exam providers), license, travel (except for medications and injections for anticipated illness while traveling), or insurance purposes that are not deemed medically necessary by Group Health for early detection of disease, all diagnostic services not specifically stated under Preventive Services
- Cosmetic services related to sexual reassignment surgery including treatment for complications resulting from cosmetic surgery; cosmetic surgery; complications of non-Covered Services; travel
- Services and supplies related to sexual reassignment surgery, such as sex-change operations or transformations and procedures, or treatments designed to alter physical characteristics, unless specifically stated under the transgender service benefit
- Procedures and services to reverse a sterilization, diagnostic testing and medical treatment of sterility, infertility, and sexual dysfunction regardless of origin or cause, unless otherwise noted under the [What the plan covers](#) section
- Services or supplies not specifically listed as covered under the [What the plan covers](#) section
- The cost of services and supplies resulting from a member's loss of or willful damage to appliances, devices, supplies, and materials covered by Group Health for the treatment of disease, injury, or illness
- Orthoptic therapy (eye training)
- Specialty treatment programs such as weight reduction, behavior modification programs and rehabilitation
- Hypnotherapy and all services related to hypnotherapy
- Prognostic (predictive) genetic testing and related services, unless specifically provided in [hospital care](#) benefit. Testing for individuals not enrolled in the plan (for example, surrogate parent).
- Fetal ultrasound in the absence of medical indications
- Liquid diet or fasting programs, membership in diet programs or health clubs, wiring of the jaw, and complications from surgery or fasting programs; however, medically necessary surgery may be covered if specific criteria as determined by Group Health is met
- Services or supplies for which no charges are made, or for which a charge would not have been made if the member had no health care coverage or for which the member is not liable; services provided by a member of the member's family or self-care
- Autopsy and associated expenses
- Services provided by government agencies, except as required by federal or state law
- Services covered by the national health plan of any other country the member resides in
- Internally implanted insulin pump, artificial heart, artificial larynx, and any other implantable device that has not been approved by Group Health's medical director

Dental benefits exclusions

Dentist's or oral surgeon's fees; dental care, surgery, services, and appliances, including: reconstructive surgery to the jaw in preparation for dental implants, dental implants, periodontal surgery, and any other dental services not specifically listed as covered in this summary.

Convalescent care exclusions

Convalescent care is excluded.

Investigational or experimental treatment exclusions



Experimental or investigational services, equipment, and drugs have not been approved by the U.S. Food and Drug Administration (FDA) for the specified use. Review the [glossary](#) for a full definition.



The transplant benefit doesn't cover cornea transplantation, skin grafts, or the transplant of blood or blood derivatives (except for bone marrow or stem cells). These procedures are covered on the same basis as any other covered surgical procedure.

Group Health consults with Group Health's medical director and then uses the following criteria to decide if a particular service is experimental or investigational:

- A service is considered experimental or investigational for a member's condition if any of the following statements apply to it at the time the service is or will be provided to the member:
 - The service cannot be legally marketed in the United States without the approval of the Food and Drug Administration (FDA) and such approval has not been granted
 - The service is the subject of a current new drug or new device application on file with the FDA
 - The service is the trialed agent or for delivery or measurement of the trialed agent provided as part of a qualifying Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial
 - The service is provided pursuant to a written protocol or other document that lists an evaluation of the service's safety, toxicity, or efficacy as among its objectives
 - The service is under continued scientific testing and research concerning the safety, toxicity, or efficacy of services
 - The service is provided pursuant to informed consent documents that describe the service as experimental or investigational, or in other terms that indicate that the service is being evaluated for its safety, toxicity, or efficacy
 - The prevailing opinion among experts as expressed in the published authoritative medical or scientific literature is that (1) the use of such service should be substantially confined to research settings, or (2) further research is necessary to determine the safety, toxicity, or efficacy of the service
- The following sources of information will be exclusively relied upon to determine whether a service is experimental or investigational:
 - The member's medical records
 - The written protocol(s) or other document(s) pursuant to which the service has been or will be provided
 - Any consent document(s) the member or member's representative has executed or will be asked to execute, to receive the service
 - The files and records of the Institutional Review Board (IRB) or similar body that approves or reviews research at the institution where the service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body
 - The published authoritative medical or scientific literature regarding the service, as applied to the member's illness or injury, and

- Regulations, records, applications, and any other documents or actions issued by, filed with, or taken by, the FDA, or other agencies within the United States Department of Health and Human Services, or any state agency performing similar functions

Coverage decisions may be appealed as set forth in the [What the plan covers](#) section.

Vehicle insurance exclusions

- Any services to the extent benefits are "available" to the member as defined herein through vehicle, homeowner's, property, or other insurance policy, except for individual or Group Health insurance, whether the member asserts a claim or not
- Medical coverage, medical "no fault" coverage, personal injury protection coverage, or similar medical coverage in the policy
- Benefits are deemed to be "available" to the member if the member is a named insured, comes within the policy definition of insured, or otherwise has the right to receive first-party benefits under the policy

Additional exclusions and limitations

In addition, certain exclusions and limitations apply to the following benefits. CTRL+Click to navigate to the benefit information.

- [Acupuncture](#)
- [Autism/ABA therapy](#)
- [Devices, equipment, and supplies](#)
- [Home health care](#)
- [Hospice care](#)
- [Hospital care](#)
- [Manipulative therapy](#)
- [Maternity and pregnancy care](#)
- [Mental health and substance abuse](#)
- [Naturopathy](#)
- [Neurodevelopmental therapy for children](#)
- [Nutritional services](#)
- [Obesity-related surgery](#)
- [Plastic and reconstructive services](#)
- [Podiatric services](#)
- [Prescription drugs](#)
- [Preventive care](#)
- [Rehabilitation](#)
- [Skilled nursing facility](#)
- [Sterilization](#)
- [TMJ](#)
- [Transplants](#)
- [Weight Management program](#)

How to file a claim

In most cases, when you receive care from a Group Health provider or facility, your provider will submit bills directly to Group Health, and this submission is your claim for benefits. If your provider does not submit a bill directly to Group Health, you will need to submit a claim for benefits.

If possible, you should submit the claim form within 90 days of the service. The plan will not consider claims submitted more than 12 months after the date of service, except in the absence of legal capacity. Claims for benefits may be made before or after services are obtained.

To submit a claim:

1. Download the [Group Health Claim Form](#) or call Group Health Customer Service at (206) 901-4636 or (888) 901-4636 to request a form
2. Complete the form with the necessary information such as an itemization of services received including codes and conditions. Proof of payment is also required if members are seeking reimbursement.
3. Gather copies of your receipts from your covered visit
4. Send your completed form and additional paperwork to:
Claims Reimbursement
PO BOX 34585
Seattle WA 98124-1585



COBRA-eligibility claims should be submitted as described in the [Continuation of coverage for health benefits](#) section.

*Claims regarding plan eligibility for you, your spouse/domestic partner, or dependent child can be sent to:
Appeals Coordinator
Premera Blue Cross
P.O. Box 91102
Seattle, WA 98111-9202.*

Claim review and payment

Group Health will send you an Explanation of Benefits (EOB) or other communication notifying you of their decision on your claim within the following timeframes after Group Health receives your claim.

- **Pre-service claims**—Group Health will provide notice of a claim approval or denial within 15 days. This 15-day period may be extended for an additional 15 days if the extension is required due to matters beyond Group Health's control. You will have at least 45 days to provide any additional information requested of you by Group Health.
- **Claims involving urgently needed care**—If your claim involves urgent care, you or your authorized representative will be notified of Group Health's initial decision on the claim, whether adverse or not, as soon as is feasible, but in no event more than 72 hours after receiving the claim. If the claim does not include sufficient information for the Plan Administrator to make a decision, you or your representative will be notified within 24 hours after receipt of the claim of the need to provide additional information. You will have at least 48 hours to respond to this request; Group Health then must inform you of its decision within 48 hours of receiving the additional information.
- **Concurrent care claims**—If your claim is one involving concurrent care, Group Health will notify you of its decision, whether adverse or not, within 24 hours after receiving the claim. If the claim does not include

sufficient information for the Plan Administrator to make a decision, you or your representative will be notified within 24 hours after receipt of the claim of the need to provide additional information. Where urgent care is involved, you will have at least 48 hours to respond to this request. Group Health will respond within 24 hours of receipt of the additional information. If the claim does not involve urgent care, the request may be treated as a new benefit claim and decided within the timeframes appropriate to the type of claim, (i.e., as a pre-service claim or a post-service claim).

- **Post-service claims**—If you have filed a post-service claim for reimbursement of medical care services that already have been rendered, you will be notified of Group Health's decision on your claim if it is denied in whole or in part. This notification will be issued no more than 30 days after Group Health receives the claim. Group Health may extend this 30-day period for up to 15 days if the extension is required due to matters beyond Group Health's control. You will have at least 45 days to provide any additional information requested of you by Group Health, if the need for the extension is due to Group Health's need for additional information from you or your health care providers.



Explanation of benefits (EOB) is the statement you receive from Group Health Cooperative detailing how much the provider billed, how much (if any) the plan paid, and the amount that you owe the provider (if any).

In paying for services, Group Health may make payment to the employee, provider or another carrier. Group Health may also make payments on behalf of an enrolled child to a non-enrolled parent or state agency to which the plan is required by applicable law to direct such payments. Payments are subject to applicable law and regulation. Payments made will discharge the plan to the extent of the amount paid, so that the plan is not liable to anyone due to its choice of payee.

Denied claims notice

If all or part of your claim is denied, Group Health will send you an Explanation of Benefits (EOB) or other notice with the following information:

- The reasons for the denial
- The plan provisions on which the denial is based
- Any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary
- An explanation of the procedure for appeals and the applicable time limits, along with a statement of your right to bring a civil action under ERISA Section 502(a) upon an adverse decision on appeal
- A statement regarding any internal rule, guideline, protocol, or other criterion that was relied upon in making the adverse determination (a copy of which will be provided free upon request)
- If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment that led to this determination (a copy of which will be provided free upon request)
- If you have filed a claim with Group Health relating to plan eligibility, and this claim is denied, Group Health will send you a notice explaining your appeal rights
- Notice regarding your right to bring legal action following a denial on appeal

For medical and transplant benefits, the denial will also include:

- Information sufficient to identify the claim involved, including the date of service, health care provider and claim amount, if applicable
- The denial code and its meaning
- A description of the Plan's standard for denying the claim
- Information regarding available internal and external appeals, including how to initiate an appeal; and
- Contact information for Group Health Customer Service or the Employee Benefits Security Administration (EBSA) of the U.S. Department of Labor to assist members with the internal and external appeals process

Appeal for internal review

Members are entitled to appeal through the appeals process if/when coverage for an item or service is denied due to an adverse determination made by the Group Health medical director. Assistance is available to Members who are limited-English speakers, who have literacy problems, or who have physical or mental disabilities that impede their ability to request review or participate in the review process. If the plan denies your claim, you may appeal for an internal review of the decision within 180 days of receiving the Explanation of Benefits (EOB).



An **appeal** is a written request to reconsider a written or official verbal adverse determination to deny, modify, reduce or end payment, coverage or authorization of health care coverage or eligibility to participate in the plan. This includes admissions to and continued stays in a facility. The process also applies to Flexible Spending Account appeals for reimbursement but does not apply to appeals of denied COBRA eligibility claims.



If you fail to file the internal appeal within this timeframe, you will permanently lose your right to appeal the denied claim.

Submitting an appeal for internal review

You must provide the following information as part of your oral or written appeal to Group Health Cooperative's Member Appeals Department:

- Your name
- Your Group Health member number
- The name of this plan, and
- A concise statement of why you disagree with the decision, including facts or theories supporting your claim

Your written request may (but is not required to) include issues, comments, documents, and other records you want considered in the review.



The appeal should be submitted to Group Health at the following address:

Group Health Cooperative
Member Appeal Department,
PO Box 34593,
Seattle, WA 98124-1593

You may, at your own expense, have an attorney or other representative act on your behalf. If you want to appoint someone to act for you in the appeals process (including your provider), you must submit a completed and signed [Group Health Appointment of Representative form](#) with your written internal appeals request to the address above.

In the case of an urgent care claim, you may submit your appeal request orally or in writing and all necessary information may be transmitted between you and the plan by telephone, facsimile or other similarly expeditious method. If your provider believes your situation is urgent as defined under law and so notifies Group Health, your appeal will be conducted on an expedited basis. Notification will be furnished to you as soon as possible, but not later than 72 hours after receipt of the expedited appeal. Your appeal should clearly indicate your request for an expedited appeal.

You may also begin an external review at the same time as the internal appeals process if this is an urgent care situation or you are in an ongoing course of treatment. To request this step, you must call Member Appeals. The external review agency is not legally affiliated or controlled by Group Health. The external review agency decision is final and is generally binding upon the Plan.



To file an urgent care appeal request, you may call Group Health directly at (866) 458-5479 or you may fax a request to (206) 901-7340.

Internal review and timeframe

All of the information you submit will be taken into account on appeal, even if it was not reviewed as part of the initial decision. You may ask to examine or receive free copies of all pertinent Plan documents, records, and other information relevant to your claim by asking Group Health.

The plan may consult with a health care professional who has experience in the field of medicine involved in the medical judgment to decide your appeal. You may request the identity of medical experts whose advice was obtained by the plan in connection with your initial claim denial, even if their advice was not relied upon in making the initial decision.

In the event any new or additional information (evidence) is considered, relied on or generated by Group Health in connection with your appeal, Group Health will provide this information to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Group Health, Group Health will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that that you will have an opportunity to respond.

If the claim is a post-service claim, you will receive a decision within a reasonable period of time, but not later than 60 days after receipt of your appeal request.

If the claim is a pre-service claim, you will receive a decision within a reasonable period of time, but not later than 30 days after receipt of your appeal request.

Denied appeal notice

If the previous denial is upheld in whole or in part, the notice of the decision on appeal will specify:

- The reasons for the denial
- The Plan provisions on which the denial is based
- A contact point through which the member may review or receive free copies of any documents, records or other information relevant to your claim for benefits
- A statement of your right to bring a civil action under ERISA 502(a) following an adverse benefit determination upon the conclusion of your appeal
- A statement regarding any internal rule, guideline, protocol or other criterion that was relied upon in making the adverse determination (a copy of which will be provided free upon request)
- If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment that led to this determination (a copy of which will be provided free upon request)

For medical and transplant benefits, the denial will also include:

- Information sufficient to identify the claim involved, including the date of service, health care provider and claim amount, if applicable
- The denial code and its meaning
- A description of the Plan's standard for denying the claim
- Information regarding available internal and external appeals, including how to initiate an appeal; and
- Contact information for Group Health Customer Service or the Employee Benefits Security Administration (EBSA) of the U.S. Department of Labor to assist members with the internal and external appeals process

If Group Health fails to grant or reject your request within the applicable required timeframe, you may proceed as if the claim had been rejected.

Appeal for external review

If you are not satisfied with the final internal denial of your claim, you may request an external review by an independent review organization (IRO) if that denial is based on medical judgment including:

- Requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit
- A determination that a treatment is experimental or investigational



An **independent review organization (IRO)** is an independent organization of medical experts who are qualified to review medical and other relevant information.

The external review is available only after you have properly exhausted the internal appeal as described above. There are no fees or costs imposed on you as part of the external review.

The external review agency decision is final and is generally binding upon the plan.

Submitting an appeal for external review

An [External Review Request Form](#) will be sent with your Internal Appeal determination letter notifying you of your rights to an External Review.

To initiate the External Review, you must complete and sign the External Review Request Form and send it to Group Health at the address below no later than 180 days after the date you receive your Internal Appeal determination letter, which the Plan deems to be 7 days after the date on the Internal Appeal determination letter.



If you fail to submit the completed and signed form within this timeframe, you will permanently lose your right to an External Review.



Mail the External Review Request form to:

Group Health Cooperative
Member Appeal Department
P.O. Box 34593
Seattle, WA 98124-1593

External review and timeframe

If your claim is eligible for External Review, Group Health will notify the IRO of your request for an External Review and send them all the information included in your Internal Appeal and other relevant materials within six days of receipt.

The IRO will contact you and/or Group Health directly if additional information is needed. Group Health will provide the IRO with any additional information the IRO requests that is reasonably available. The External Review request is considered complete when the IRO has all the requested information and the IRO review begins.



If your provider believes your situation is urgent under law (as defined above under Appeal for internal review), your external review will be conducted on an expedited basis. For expedited external reviews, you and Group Health will be notified by phone, e-mail message or fax as soon as possible, but no later than 72 hours after receipt of your external review request. A written determination will follow.

The plan agrees that any statute of limitations (including the one-year contractual limitations period described below) or other defense based on timeliness is on hold during the time that the External Review is pending. Your decision whether to file the External Review will have no effect on your rights to any other benefits under the plan.

The external review process does not apply to appeals of denied claims for plan eligibility or for other appeals of denied claims that are not based on medical judgment.

Decision on the external review

The plan is bound by the IRO's decision. If the IRO overturned the final internal adverse determination, the plan will implement their decision. The IRO will notify you and Group Health in writing of its determination on the external review no later than 45 days after receipt of your complete external review request.

Decisions upon the external review are the final decision under the Plan's appeal process, and there are no further appeals available from Group Health or Microsoft or any person administering claims or appeals under the plan. However, you still have the right to file suit under ERISA Section 502(a) as a result of the external review decision.

Limits on your right to judicial review

You must follow the appeals process described above through the decision on the appeal before taking action in any other forum regarding a claim for benefits under the plan. Any legal action initiated under the Plan must be brought no later than one year following the adverse determination on the appeal. This one-year limitations period on claims for benefits applies in any forum where you initiate legal action. If a legal action is not filed within this period, your benefit claim is deemed permanently waived and barred.



If you have questions about understanding a denial of a claim or your appeal rights, you may contact Group Health at (206) 901-4636 or (888) 901-4636 or visit Group Health Cooperative online. You may also seek assistance from the Employee Benefits Security Administration (EBSA) of the U.S. Department of Labor at (866) 444-EBSA (3272).

Right to recover benefits paid in error

If Group Health makes a payment in error on your behalf to you or a provider, and you are not eligible for all or a part of that payment, Group Health has the right to recover payment including deducting the amount paid by mistake from future benefits.

Note: Health care providers are not “beneficiaries” of the plan, and although Premera may make direct payment to health care providers for the convenience of participants and their dependents, such payments of services shall not be considered “benefits” available under the plan, or confer beneficiary standing upon a health care provider.

Release of medical information

As part of this plan, physicians, hospitals or other providers may disclose to Group Health medical information necessary to administer claims. Group Health will keep this information confidential.

HMO Plan (Kaiser Permanente) – California only


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How the plan works

The Kaiser Permanente HMO Plan offers the convenience of “one-stop shop” medical care. Your providers are all part of the same integrated health care system so they can quickly share your medical records to help make informed decisions about your care. There’s also a pharmacy, laboratory, and X-ray facility at every Kaiser Permanente location, so it’s easy and efficient to get the care you need, when you need it.

Where you can get care

The HMO Plan provides comprehensive medical care and prescription drug coverage with contracted providers, facilities, and pharmacies through the Kaiser Permanente network in California and eight other states. Group Health Cooperative facilities are treated as part of the Kaiser Permanente network if you need medical services while in Washington State. Services provided outside the Kaiser Permanente’s service area may not be covered. You may need a referral from your primary care physician before the plan will cover care from specialists.

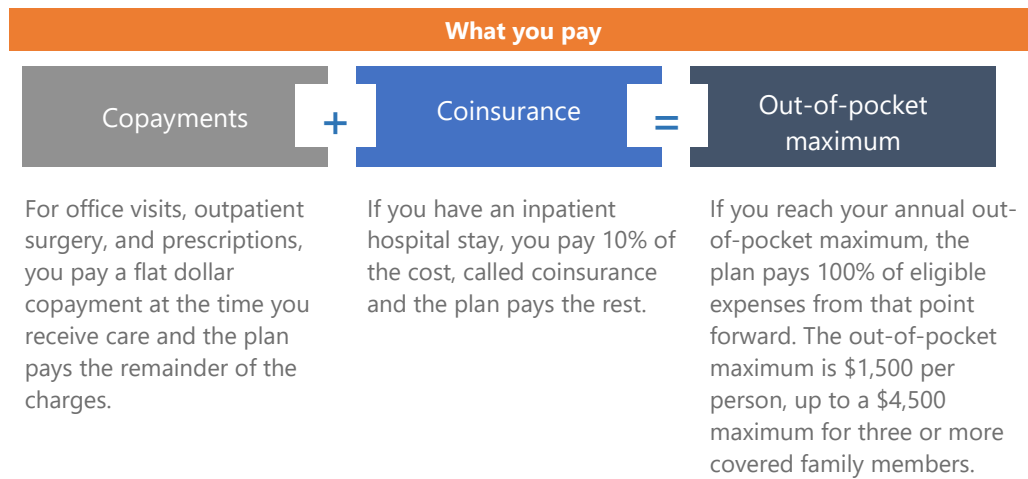


To find an in-network provider of pharmacy, go to www.KP.org or contact the Member Service Contact Center at (800) 464-4000.

What you pay

When you receive care for the treatment of illnesses, injuries, and chronic conditions, you pay a portion of the cost, up to an annual out-of-pocket maximum. For most services such as office visits, outpatient surgery, and prescriptions, you pay a flat copayment at the time you receive care and the plan pays the remainder of the cost. If you have an inpatient hospital stay, the plan pays 90% of the cost and you are responsible for 10% up to

an annual out-of-pocket maximum. When it comes to preventive care and preventive prescriptions, the plan covers 100% when you use in-network providers.



Copayment is a fixed, up-front dollar amount that you are required to pay for certain covered services in the HMO plans.

Coinsurance is the percentage amount that you are required to pay for certain covered services.

Out-of-pocket maximum is the most you could pay each plan year for covered services and supplies.

Medical care copayments

Type of visit	Copayment	Coinsurance
Primary Care Physician	\$20	None
Specialist	\$40	None
Emergency (waived if admitted)	\$75	None
Hospital – outpatient	\$100	None
Hospital – inpatient	None	10%

Prescription drug copayments

(When prescribed by a Kaiser provider and obtained at a Kaiser pharmacy)	Copayment
Generic	\$10
Brand	\$25



Generic drugs are equivalent to a brand-name drug but available at a lower cost because the patent has expired.

Brand-name drugs are sold under a trademark name. An equivalent generic drug may or may not be available at lower cost, depending upon whether the patent on the brand-name drug has expired.

Out-of-pocket maximum

The annual out-of-pocket maximum is capped at \$1,500 for each covered member—this means that once a member reaches his/her out-of-pocket maximum through copayments and coinsurance, the plan pays 100% for the rest of the year for that individual. Also, if you have three or more covered family members, the most you'll pay for the year is \$4,500. Most copays and coinsurance count toward the annual out-of-pocket maximum, with the exception of prescription drugs and infertility treatment.

What the plan covers

Benefits under this Kaiser Permanente HMO are detailed in the Evidence of Coverage (separate documents for Northern California and Southern California coverage, respectively), which are incorporated by reference in this SPD.

- [Evidence of Coverage – Northern California](#)
- [Evidence of Coverage – Southern California](#)

Exclusions and limitations

Exclusions and Limitations under this Kaiser Permanente HMO are detailed in the Evidence of Coverage (separate documents for Northern California and Southern California coverage, respectively) which are incorporated by reference in this SPD.

- [Evidence of Coverage – Northern California](#)
- [Evidence of Coverage – Southern California](#)



Additional exclusions that apply only to a particular benefit are listed in the description of that benefit in the Benefits and Cost Sharing section in the Evidence of Coverage.

How to file a claim

If you wish to file a claim for benefits, you should follow the claim procedures described in the Evidence of Coverage provided by your Claims Administrator. All questions regarding claims should be directed to the Claims Administrator for the Kaiser Permanente Health Plan.

- [Evidence of Coverage – Northern California](#)
- [Evidence of Coverage – Southern California](#)



For more information about filing a claim, contact the Member Services Contact Center at (800) 464-4000.

Hawaii-Only Plan (Premera)

What is in this section

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How the plan works

The Hawaii-Only Plan provides comprehensive medical coverage and the flexibility to see any provider you choose. Preventive care is covered at 100% with in-network providers and facilities and you pay a share of other expenses up to an annual maximum amount.

Where you can get care

With the Hawaii-Only Plan, you have the flexibility to visit the provider or facility you choose and still have coverage. However, providers in the nationwide Premera Blue Cross Blue Shield network feature certain advantages, including:

- Your claims are filed directly with Premera by your provider
- Lower, negotiated rates for care and prescriptions
- The highest coverage levels

If you seek care with an out-of-network provider or facility, your out-of-pocket costs will be higher, and you may have to pay the provider and then submit a claim for reimbursement

Please review the [What you pay](#) section for information on coverage levels.

Finding an in-network provider

In Hawaii, you can maximize your savings by using providers and facilities in the Premera network.

Outside of Hawaii, you may use any Blue Cross and/or Blue Shield provider throughout the United States, the Commonwealth of Puerto Rico, Jamaica, and the British and U.S. Virgin Islands under the [BlueCard®](#) Program. Your Premera identification card tells contracting providers that you are covered through this inter-plan arrangement. It's important to note that receiving services through BlueCard does not change covered benefits, benefit levels, or any stated residence requirements of this plan.



Visit the online [Premera Medical Directory](#) to find an in-network provider in the United States.

Travel outside the United States

If you are traveling outside the United States, the Commonwealth of Puerto Rico, Jamaica and the British and U.S. Virgin Islands and need care, you may be able to take advantage of [BlueCard Worldwide®](#), which provides referrals to doctors and other health care providers.



Call (800) 810-BLUE (2583) for BlueCard Worldwide referrals to health care providers outside the United States, the Commonwealth of Puerto Rico, Jamaica, and the British and U.S. Virgin Islands.

You will need to submit claim forms to Premiera for reimbursement of services received outside the United States, including services through BlueCard Worldwide. When you submit a claim, clearly detail the services received, diagnosis (including standard medical procedure and diagnosis code, or English nomenclature), dates of service, and the names and credentials for the attending provider. Benefits reimbursement will be calculated in U.S. dollars.

Care received outside the United States will be covered at out-of-network levels as long as the services are:

- Medically necessary
- Provided by a licensed provider performing within the scope of his or her license and practice
- Not deemed experimental or investigational based on the terms of this plan, or medical standards in the United States

Services received outside the United States that are considered urgent or emergent including services received on a cruise ship will be paid as [emergency care](#).



Experimental or investigational services, equipment, and drugs have not been approved by the U.S. Food and Drug Administration (FDA) for the specified use. Review the [glossary](#) for a full definition.



Please review the [What you pay](#) section for information on coverage levels.

Filling a prescription

Depending on your needs, you may fill your prescription at a retail pharmacy, pharmacy home delivery, or specialty pharmacy. Review the [prescription drug](#) benefit for more information on what is covered.



Microsoft reserves the right to change pharmacy networks at any time. Such changes will take effect on the date set by the Company, even if this information has not been revised to show the changes. Members will be given written notice in advance of such changes.

	Retail pharmacy	Home delivery	Specialty pharmacy
Coverage	<ul style="list-style-type: none"> • Up to a 90-day supply for generic maintenance medication; all others are up to a 30-day supply* 	<ul style="list-style-type: none"> • Up to 90-day supply* 	<ul style="list-style-type: none"> • Up to a 30-day supply* • Additional clinical support for members using specialty drugs

	Retail pharmacy	Home delivery	Specialty pharmacy
In-network pharmacies	<ul style="list-style-type: none"> Express Scripts pharmacies bill the plan on your behalf To find an Express Scripts retail pharmacy, call (800) 676-1411 	<ul style="list-style-type: none"> Express Scripts pharmacies bill the plan on your behalf 	<ul style="list-style-type: none"> Contracted specialty pharmacies bill the plan on your behalf
Out-of-network pharmacies	<ul style="list-style-type: none"> You will need to submit a prescription reimbursement form, with your receipt, for reimbursement 	<ul style="list-style-type: none"> You will need to submit a prescription reimbursement form, with your receipt, for reimbursement 	<ul style="list-style-type: none"> You will need to submit a prescription reimbursement form, with your receipt, for reimbursement

* Unless the drug maker's packaging limits the supply in some other way.



A **prescription drug** is any medical substance that cannot be dispensed without a prescription according to federal law. Only medically necessary prescription drugs are covered by this plan.

Generic maintenance medications have a common indication for the treatment of a chronic disease (such as diabetes, high cholesterol, or hypertension). Indications are obtained from the product labeling. They are used for diseases when the duration of the therapy can reasonably be expected to exceed one year. A generic prescription drug is manufactured and distributed after the brand-name drug patent of the innovator company has expired, and is available at a lower cost than brand-name prescriptions. Generic drugs have obtained an AB rating from the U.S. Food and Drug Administration and are considered by the FDA to be therapeutically equivalent to the brand-name product.

Specialty drugs are high-cost drugs, often self-injected and used to treat complex or rare conditions, including rheumatoid arthritis, multiple sclerosis, and hepatitis C. Specialty drugs may also require special handling or delivery. These medications can be dispensed only for up to a 30-day supply.

Prior Authorization

Prior authorization, also referred to as a pre-service review, is recommended for some services and prescriptions to determine that coverage is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.



Prior authorization is an advance determination by Premera that the service or prescription is medically necessary and that the member's plan has benefits available for the service being requested. This determination is offered in certain situations where medical records must be provided to establish medical necessity before the plan will pay for the service. Services are subject to eligibility and benefits at the time of service.

Refer to the specific plan benefit for additional details.

What you pay

You pay nothing for preventive care when you use in-network providers. When you receive other care or prescription drugs, such as for the treatment of illnesses, injuries, and chronic conditions, you pay a portion of the cost up to an annual maximum amount. That annual amount, called your out-of-pocket maximum, includes a deductible and coinsurance. If you use in-network providers, you'll receive the lower Premera-negotiated rate,

called the allowable charge, and higher coverage levels. Examples of how the plan pays for in- and out-of-network care follow on the next page.

What you pay		
Deductible	+	Coinsurance = Out-of-pocket maximum
You pay 100% of your eligible expenses for medical care and prescriptions until you spend up to the amount of the deductible. Only the Premera allowable charge is applied to your deductible if you seek out-of-network care. You pay nothing for in-network preventive care.		<p>If you reach the deductible, then you begin to pay coinsurance up to a capped amount called the coinsurance maximum. That means you pay only a portion of your health care costs and the plan pays the rest. The coinsurance amount you pay depends on where you seek care:</p> <ul style="list-style-type: none"> • In-network, you pay 10% • Out-of-network, you pay 30% of the allowable charge plus the difference between the provider's bill and the allowable charge; only the allowable charge is applied to your coinsurance maximum. <p>If you meet your deductible and then you reach your coinsurance maximum, you've reached your out-of-pocket maximum. From that point forward, the plan pays 100% of eligible expenses and you pay nothing for in-network health care services for the rest of the year. You will still be responsible for the difference between the allowable charge and the provider's billed charges if you seek out-of-network care.</p>
\$300 per person, up to \$900 family maximum		<p>\$1,200 per person, up to \$3,600 family maximum</p> <p>\$1,500 per person, up to \$4,500 family maximum</p>



An **allowable charge** is the negotiated amount that Premera in-network providers have agreed to accept as payment in full for a covered service. Out-of-network providers may not accept the allowable charge as payment in full. If you choose to use out-of-network providers, only the allowable charge will apply toward your deductible, coinsurance maximum, and out-of-pocket maximum, as applicable. You are responsible for paying the difference between the allowable charge and the amount your out-of-network provider charges.

Example

Jakob needs to visit his allergist. He can choose an in-network or an out-of-network provider. Both charge \$115. The in-network provider accepts Premera's allowable charge of \$100 as full payment. Jakob hasn't yet met his deductible, so he will pay the allowable charge of \$100 to his in-network provider. The out-of-network provider does not have the negotiated agreement with Premera, so Jakob would pay the full \$115, and only the allowable charge of \$100 would apply to his deductible.

Example

Mimi needs to see her podiatrist. The visit costs \$125 and the allowable charge is \$100. Mimi has met her deductible, so she'll pay just \$10 for her visit if she uses an in-network provider (\$100 x 10% coinsurance). If she visits an out-of-network provider, she would pay \$55:

- 30% of the \$100 Premera allowable charge (\$100 x 30% coinsurance = \$30)
- Plus the difference between the out-of-network provider's bill and the allowable charge (\$125-\$100=\$25)

Example

Kunji has an ear infection. The provider visit costs \$175 and the allowable charge is \$150. Kunji has met her out-of-pocket maximum, so she'll pay nothing if she visits an in-network provider.

If she visits an out-of-network provider, she'll pay \$25, the difference between the out-of-network provider's bill and the allowable charge (\$175-\$150=\$25)

Expenses NOT applied to the deductible or coinsurance

The following services are covered by the plan at 100% with in-network providers and do not count toward the deductible or coinsurance maximum.

- [Preventive care](#)
- Care received through the [Microsoft CARES employee assistance program](#)

Certain other expenses are your responsibility to pay and do not count toward the annual deductible or coinsurance maximum. They include:

- Expenses incurred while the member was not covered under the plan
- Expenses for services, supplies, settings, or providers that are not covered under this plan
- Expenses in excess of annual or lifetime benefit maximums that apply to certain plan benefits
- Amounts for out-of-network care in excess of the allowable charge for the service or supply
- Coinsurance for services covered under the [Weight Management program](#)

Additionally, charges for medical services received during business travel that are applied to the deductible or coinsurance are not a reimbursable business expense.

Out-of-network care with in-network coverage

You may seek out-of-network care and receive in-network coverage levels in the following situations:

Situation	Benefit coverage	What you need to do
Emergency care	Benefits are provided regardless of network status	Go to the nearest emergency facility
You cannot find the provider specialty that you need in the Premera network	If the Premera network does not include a provider specialty (such as a speech therapist) anywhere in your state, treatment at out-of-network providers may be paid at the in-network level	To confirm this coverage is available, please contact Premera at (800) 676-1411
Your provider's contract with Premera is ending	If you are receiving ongoing treatment (such as a physical therapy) you may be eligible to continue to receive in-network benefits for the current course of treatment, for a specific time period	To confirm this coverage is available, please contact Premera at (800) 676-1411 prior to the end of your provider's contract with Premera

Annual and lifetime maximums

There is no overall annual or lifetime maximum in the Hawaii-Only Plan. However, annual and lifetime maximums apply to certain benefits. Please review the [What the plan covers](#) section for details on annual and lifetime benefit maximums.



A **lifetime benefit maximum** is the most a plan will pay toward a benefit for a member. Review the [glossary](#) for a full definition.

Example

There is a \$15,000 lifetime infertility lifetime benefit maximum per eligible member (employee, spouse/domestic partner) and a \$6,000 weight management program lifetime benefit.

What the plan covers

The tables below summarize what the Hawaii-Only Plan covers, including what the plan pays for in-network and out-of-network care.



Services and supplies must be medically necessary and are subject to all benefit exclusions and limitations and the plan's [Exclusions and limitations](#).



CTRL+Click on the benefits below to access more information.

Common benefits		
These are the most commonly used benefits in the Hawaii-Only Plan.		
Benefit	In-network coverage	Out-of-network coverage
Preventive Care Including well-child care through age 11, annual routine physical exams age 12 and up, routine gynecological exams and immunizations (See the Preventive Care Services list)	100%	70% of allowable charges after deductible; well-child care through age 6 covered at 100%
Prescription drugs	90% after deductible	90% after deductible
Physician services Including specialists and second surgical opinions rendered in the office, hospital, or other medical facility	90% after deductible	70% of allowable charges, after deductible
Lab tests & X-rays	90% after deductible	90% of allowable charges, after deductible

Common benefits		
These are the most commonly used benefits in the Hawaii-Only Plan.		
Benefit	In-network coverage	Out-of-network coverage
Hospital inpatient care Including semi-private room and board, anesthesia, supporting services, testing, supplies, and intensive or coronary care	90% after deductible	70% of allowable charges, after deductible
Hospital outpatient care/ambulatory surgical care center Including minor surgery, X-ray and radium therapy, anesthesia, and pre-admission testing	90% after deductible	70% of allowable charges, after deductible
Urgent care	90% after deductible	70% of allowable charges, after deductible
Rehabilitation – Physical, Occupational and Speech Therapies	90% after deductible	70% of allowable charges, after deductible
Contraception Contraceptive devices and injections administered by a physician and prescription forms of contraception.	100%	100%
Maternity care (Other than hospital inpatient or outpatient care)	90% after deductible	70% of allowable charges, after deductible
Mental health, Attention Deficit Disorder, substance abuse, and alcoholism treatment	Outpatient services through Microsoft CARES employee assistance program : <ul style="list-style-type: none"> • 100% up to three visits per member per calendar year • 100% up to three telephonic counseling sessions per member per calendar year • 100% up to eight visits per family for family or couples counseling per calendar year 	
	90% after deductible for inpatient and outpatient services	70% of allowable charges, after deductible for inpatient and outpatient services

Other benefits		
The Hawaii-Only Plan also covers these additional benefits.		
Benefit	In-network coverage	Out-of-network coverage
Ambulance	90% after deductible	90% after deductible
Chiropractic services, acupuncture, and medical massage	90% after deductible	70% of allowable charges, after deductible
	Combined 24-visit limit per member per calendar year	
Diabetes health education	100%	70% of allowable charges, after deductible
Emergency room care and professional services	90% after deductible	90% after deductible
Hearing care and hardware	Exams: 90% after deductible	Exams: 70% of allowable charges, after deductible
	Hardware: 90% after deductible; \$3,000 hardware limit per member in a period of three consecutive calendar years	
Home health care	90% after deductible	70% of allowable charges, after deductible
Hospice care	90% after deductible	90% after deductible
Medical equipment and supplies	90% after deductible	90% of allowable charges, after deductible
Nutritional therapy	100%	70% of allowable charges, after deductible
	First 12 visits per member per calendar year, calendar year visit limit waived for nutritional therapy for a diagnosed eating disorder or diabetes.	
Skilled nursing facility	90% after deductible; up to 120 days per calendar year	70% of allowable charges, after deductible; up to 120 days per calendar year
	120-day limit per member per calendar year	
Surgical weight loss treatment Covered when criteria listed in the Premera Medical Policy on Surgery for Morbid Obesity are met	90% after deductible	70% of allowable charges, after deductible
Temporomandibular joint (TMJ) dysfunction	90% after deductible	70% of allowable charges, after deductible
Transplants	90% after deductible	70% of allowable charges, after deductible
Vision therapy	90% after deductible	70% of allowable charges, after deductible
	32-visit lifetime benefit maximum per member	

Specialized benefits		
Microsoft provides these unique benefits to you through the Hawaii-Only Plan.		
Benefit	In-network coverage	Out-of-network coverage
Autism/Applied Behavior Analysis (ABA) therapy	90% after deductible	Not applicable
Infertility	90% after deductible	90% of allowable charges, after deductible
	Combined maximum lifetime benefit including prescription drugs of \$15,000 per member	
Transgender services	90% after deductible	90% of allowable charges, after deductible
Weight Management program Including comprehensive and clinically based weight management programs approved by Premera for the treatment of obesity	80% of charges up to a maximum lifetime benefit payment of \$6,000. Deductible and coinsurance maximum do not apply. The 20% coinsurance you pay will not count toward the deductible or coinsurance maximum and will continue after the deductible and coinsurance are met.	Not applicable

Plan benefits



The following pages provide details on what the plan covers. The plan's [Exclusions and limitations](#), including the requirement of medical necessity, apply to these benefits.

Ambulance

In-network: 90%, deductible applies

Out-of-network: 90%, deductible applies

This benefit covers licensed surface (ground or water) and air ambulance transportation to the nearest medical facility equipped to treat the condition, when any other mode of transportation would endanger the member's health or safety. This benefit is limited to the member that requires transportation.

Autism/Applied Behavior Analysis (ABA) therapy

In-network: 90%, deductible applies

Out-of-network: not applicable

This benefit covers behavioral interventions based on the principles of Applied Behavioral Analysis (ABA) through eligible providers.

Who is eligible

This benefit is available for enrolled dependent children who are diagnosed with the following conditions under Autism Spectrum Disorder:

- Autistic Disorder (International Classification of Diseases, 9th Revision, Clinical Modification)
- Childhood Disintegrative Disorder
- Asperger's Disorder
- Rett's Disorder and Pervasive Development Disorder Not Otherwise Specified/Atypical Autism
- Pervasive Developmental Disorder



- If you need assistance confirming the diagnosis your doctor provides is an eligible diagnosis for the Autism/Applied Behavioral Analysis benefit you may contact Premera Customer Service at (800) 676-1411 or email microsoft@premera.com.

Eligible providers

The benefit covers services through providers who have met established qualifications for certification (known as certified providers) and who perform services in consultation with a certified provider (known as therapy assistants).



- To find approved autism providers who are eligible for reimbursement (not including therapy assistants), review the [Certified Autism Provider list](#).
- Contact Premera at microsoft@premera.com to receive a copy of the certification criteria or for an application for providers not currently on the approved list.

For the purpose of this benefit only, services of a certified provider will be covered even if the provider does not meet the plan's requirements for an eligible provider under the [rehabilitation](#) or [mental health, substance abuse, and alcoholism treatment](#) benefits.

Covered services

Services must be ordered by the dependent's treating physician to be covered. An approved certified provider acts as the program manager for the member. Benefits are available for time used to evaluate the member and document findings and progress reports, and to create and update treatment plans; and time used to train and evaluate the work of the therapy assistants working directly with the member to implement the treatment plan.

In most cases, therapy assistants will provide the implementation portion of the treatment plan. Therapy assistant time is eligible for face-to-face time with the member to perform the tasks described in the treatment plan and to document outcomes; and time to meet with the program manager for training and to discuss treatment plan issues. Therapy Assistant services that are provided by a Program Manager will be paid at the Therapy Assistant rate.

Claims for ABA services should clearly list the level of service (certified provider/program manager; or therapy assistant), the date the service was provided, the time the service started and ended, the hourly charge for the service, and the total charge for that service. Therapy Assistant services that are provided by a Program Manager will be paid at the Therapy Assistant rate.

ABA services are not covered for the following:

- Babysitting or doing household chores

- Time spent under the care of any other professional
- Travel time
- Home schooling in academics or other academic tutoring

Benefit coverage above the allowable charges

You may be billed for charges assessed above the allowable charges since these providers have not agreed to offer discounts to members covered by this plan. Any amounts you pay for charges in excess of allowable charges, will not count towards satisfying any deductible requirements, or out-of-pocket maximums that may apply to other benefits provided through this plan.



An **allowable charge** is the negotiated amount that providers have agreed to accept as payment in full for a covered service. Out-of-network providers may not accept the allowable charge as payment in full. You are responsible for paying the difference between the allowable charge and the amount your out-of-network provider charges.

Prior Authorization

Prior authorization, also referred to as a pre-service review, is recommended to determine coverage is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.



Prior authorization is an advance determination by Premera that the service is medically necessary and that the member's plan has benefits available for the service being requested. This determination is offered in certain situations where medical records must be provided to establish medical necessity before the plan will pay for the service. Services are subject to eligibility and benefits at the time of service.

Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition based on national, evidence-based guidelines. Premera and Microsoft reserve the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

For ABA/Autism benefits, the prior authorization requires the following documents:

- The dependent's treating physician's order for ABA services
- The clinical documentation of the qualifying diagnosis
- The Plan of treatment created by the approved program manager

For the autism/ABA therapy benefit, Premera will issue a prior authorization on this service that will pertain to a six-month period of treatment. The prior authorization process and subsequent clinical review includes the following steps:

1. The dependent child's treating physician or specialist diagnoses the child with an Autism Spectrum Disorder (Autistic Disorder, Childhood Disintegrative Disorder, Rett's Disorder, Pervasive Developmental Disorder Not Otherwise Specified, or Asperger's Disorder) and refers the child for ABA treatment
2. An initial evaluation is performed by the approved certified provider to determine if the child is a candidate for an ABA and/or related structured behavioral program. If the child is determined to be a candidate by the evaluating approved certified provider, the approved certified provider would create and submit a treatment plan including type and frequency of services planned for the immediate six-month

period. The approved certified provider must send the treatment plan to Premera so that eligibility for services can be determined.

3. Every six months, the approved certified provider who is overseeing the treatment must submit an updated treatment plan to Premera. The approved certified provider must determine that the treatment plan and services being provided are in accordance with ABA guidelines. If any substantial change in the frequency or type of program is necessary during the six-month treatment time, a revised treatment plan checklist should be submitted to Premera for notification of the revision of the treatment plan.
4. Progress reports should be created at least monthly by the certified provider to include documentation of the therapy assistant interventions and/or his or her own interventions with the child and a written summary of the child's progress. If the child has not made progress in the last six months, the updated treatment plan checklist should reflect a change in approach. Progress reports should be available to Premera upon request.

Services for this treatment that do not meet criteria described in the program are subject to retrospective denial of benefits. Claims for these services must be accompanied by a completed [Autism/ABA therapy services billing summary](#) signed by the certified provider and the dependent child's parent.

Additional exclusions and limitations for autism/ABA therapy

In addition to the plan's [Exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- This benefit is not provided for rehabilitation services (which apply under the [rehabilitation](#) benefit) or mental health services (which apply under the [mental health and chemical dependency](#) benefit)
- Benefits for services provided by volunteers, childcare providers, family members and benefits paid for by state, local and Federal agencies will not be covered. Volunteer services or services provided by a family member of the child receiving the services by or through a school, books and other training aids will also not be covered.
- Other unspecified developmental disorders or delays, or any other delay or disorder in a child's motor, speech, cognitive, or social development are not covered under this benefit
- This benefit covers only the allowable fees for eligible services performed by the approved certified provider and those providing interventions based on principles of ABA and/or related structured behavioral programs under the supervision of the approved certified provider. Other expenses associated with providing the treatment, such as the tuition, program fees, travel, meals, and lodging of the approved certified provider, expenses of those working under the approved certified provider's supervision, the dependent, and his or her family members will not be covered.

Chiropractic services, acupuncture, and medical massage therapy

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

Limit: up to 24 visits per member per calendar year chiropractic, acupuncture, and medical massage therapy (combined)

This benefit (1) covers chiropractic service from a licensed chiropractor, (2) acupuncture services provided when medically necessary to relieve pain or to treat a covered illness, injury, or condition when received from a licensed acupuncturist or a provider licensed to perform acupuncture, and (3) medical massage therapy with a physician's prescription received from a licensed massage therapist. To be covered, these services must be rendered to restore or improve a previously normal physical function and delivered within the provider's scope of practice guidelines.

These covered services must be medically necessary and will be covered only when the provider is providing the service within the scope of his or her state license.

These covered services (chiropractic services, acupuncture, medical massage therapy) provided will accrue toward the 24-visit annual maximum. For example, if you visit a chiropractor for covered services 20 times in a calendar year, you have four visits available for covered medical massage or acupuncture services in that calendar year.

Contraception

In-network: 100%

Out-of-network: 100%

This benefit covers contraceptive devices and injections for contraceptive purposes when prescribed by a physician. Included are diaphragms, IUDs, and Depo Provera injections. Removal of contraceptive devices by a physician is also covered.

Birth control medications are covered under the [prescription drug](#) benefit at 100%.

Cosmetic and reconstructive surgery

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers services, supplies, and procedures for cosmetic, plastic, or reconstructive surgery purposes, along with complications of these services, supplies, or procedures for the following:

- Repair of a defect that is the direct result of an accidental injury, providing such repair is started within 12 months of the date of the accident
- Treatment for a congenital anomaly of a child
- Treatment of visible birth marks of a covered child
- Reconstruction of the involved breast following a mastectomy. Benefits are also provided for the reduction of the non-diseased breast to make it equal in size to the diseased breast after definitive reconstructive surgery on the diseased breast has been performed. No other cosmetic breast surgery is covered.
- Correction of physical functional disorders. Benefits may include, but are not limited to, blepharoplasty or breast reduction.

The treatment plan for any of the above conditions must be prescribed by a physician.



A **congenital anomaly** is a marked difference from the normal structure of a body part that is physically evident from birth.

A **physical functional disorder** is a limitation from normal (or baseline level) of physical functioning that may include, but is not limited to, problems with ambulation, mobilization, communication, respiration, eating, swallowing, vision, facial expression, skin integrity, distortion of nearby body parts or obstruction of an orifice. The physical functional impairment can be due to structure, congenital deformity, pain, or other causes. Physical functional impairment excludes social, emotional and psychological impairment or potential impairment.

Dental services

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers certain services from a dental provider that would otherwise be covered by this plan if performed by a physician, as long as these services are provided within the scope of the dental provider's license.



Review the [Dental plan](#) section for information on your dental benefits.

Covered services

This benefit covers treatment of a fractured jaw, excision of a tumor or cyst of the mouth, and incision or drainage of an abscess or cyst of the mouth.

Facility fees and/or anesthesia fees for treating dental conditions are eligible for payment under the medical benefit if any of the following criteria are met:

- The member has a medical condition his or her physician determines would place the member at undue risk if the dental procedures were performed in a dental office or general anesthesia or IV sedation is required
- The member has a physical or mental handicap and cannot be managed with local anesthesia
- The member is a child who after other means of patient management have been tried, cannot be treated in the office setting
- The member is a child for whom other means of patient management are contraindicated

Orthodontia services may be eligible for payment under the medical plan for dependents born with cleft/lip palate or other severe craniofacial anomalies. To qualify for benefits the condition must meet medically necessary criteria in Premera's medical policy addressing orthodontia for repair of cleft palate and other severe congenital anomalies.

Prior Authorization

Prior authorization, also referred to as a pre-service review, is recommended to determine coverage is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.



Prior authorization is an advance determination by Premera that the service is medically necessary and that the member's plan has benefits available for the service being requested. This determination is offered in certain situations where medical records must be provided to establish medical necessity before the plan will pay for the service. Services are subject to eligibility and benefits at the time of service.

Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition based on national, evidence-based guidelines. Premera and Microsoft reserve the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

Additional exclusions and limitations for dental services

In addition to the plan's [Exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- Services or supplies not medically necessary for diagnosis, care, or treatment of a disease, illness, or injury
- Dental care and services of a dentist, except as provided in the dental benefit. Hospital and physician services in support of all other dental care are covered only if the care meets two conditions: (1) adequate dental treatment cannot be rendered without the use of the hospital, and (2) the member has a health problem that makes it medically necessary to do the dental work at the hospital.
- Dental services for accidental injuries to the oral and maxillofacial region are covered only when the needed corrective dental repairs are certified in writing by the dental care provider as dentally necessary and are directly related to the accidental injury. Covered dental services include the repair or replacement of existing crowns, inlays, onlays, bridgework, and dentures. The treatment must be started within one year from the date of the accident.
- Benefits for services or supplies for treatment of temporomandibular joint (TMJ) dysfunction or myofascial pain dysfunction (MPD); benefits may be available under the Microsoft temporomandibular dysfunction benefit
- The medical plan does not cover any other preventive or restorative dental procedures, regardless of origin of condition

Diabetes health education

In-network: 100%

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers outpatient self-management training and education for diabetes, including medical nutritional therapy by a dietician or nutritionist with expertise in diabetes.

Emergency room care and professional services

In-network: 90%, deductible applies

Out-of-network: 90%, deductible applies

This benefit covers hospital emergency room and provider charges—regardless of the network status—including related services and supplies, such as diagnostic imaging (including X-ray) and laboratory services, and surgical dressings and drugs furnished by and used while at the hospital.

Following discharge from the emergency room or hospital, eligible services will be paid based on the contracting status of the provider.

Regardless of network status, after being treated in the emergency department for an emergent condition and admitted to a hospital inpatient care (as defined by the [hospital inpatient care](#) benefit), along with provider charges, will be covered at the in-network level.

For emergency substance abuse treatment, see the [mental health and chemical dependency](#) benefit.

Hearing care and hardware

Hearing exams and testing

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers one routine hearing examination and one routine hearing test (or screening) per member each calendar year.

Hearing exam services include:

- Examination of the inner ear and exterior of the ear
- Observation and evaluation of hearing, such as whispered voice and tuning fork
- Case history and recommendations
- The use of calibrated equipment

Hearing hardware

In-network: 90%, deductible applies

Out-of-network: 90%, deductible applies

Limit: up to \$3,000 maximum every three years per member

This benefit covers hearing hardware up to a maximum benefit of \$3,000 per member in a period of three consecutive calendar years.

Before obtaining a hearing aid, you must be examined by a licensed physician (M.D. or D.O.) or audiologist (CCC-A or CCC-MSPA).

Benefits cover the following:

- The hearing aid(s) (monaural or binaural) prescribed as a result of an exam
- Ear mold(s)
- Hearing aid rental while the primary unit is being repaired
- The initial batteries, cords, and other necessary ancillary equipment
- A follow-up consultation within 30 days following delivery of the hearing aid with either the prescribing physician or audiologist
- Repairs, servicing, and alteration of hearing aid equipment

Additional exclusions and limitations for hearing care and hardware

In addition to the plan's [Exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- Hearing aids purchased before your effective date of coverage under this plan
- A hearing aid, for any reason, more often than once in a period of three consecutive calendar years
- Batteries or other ancillary equipment other than that obtained upon purchase of the hearing aid
- A hearing aid that exceeds the specifications prescribed for correction of hearing loss
- Expenses incurred after your coverage ends under this plan unless a hearing aid was ordered before that date and was delivered within 90 days after the date your coverage ended
- Charges in excess of this benefit; these expenses are also not eligible for coverage under other benefits of this plan

Home health care

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers visits for intermittent care by a registered nurse (RN) or licensed practical nurse (LPN), a licensed physical or occupational therapist, a certified speech therapist, social worker (MSW) working for a home health agency or a certified respiratory therapist. The benefit includes the cost of a home health aide when

acting under the direct supervision of one of the before-mentioned therapists and while performing services specifically ordered by the doctor in the treatment plan. The benefit also includes disposable medical supplies and eligible medication prescribed by a physician when provided by the home health care agency.



Intermittent care is care provided due to the medically predictable recurring need for skilled home health care services.

Home health care services provided and billed by a Medicare-approved or state-licensed home health care agency for treatment of an illness or injury are covered. The services must be part of a formal written treatment plan prescribed by your doctor.

One postpartum home health visit within 30 days of the discharge of the baby from the hospital or alternative birthing center will be eligible for coverage.

Additional exclusions and limitations for home health care

In addition to the plan's [Exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- Normal living expenses, such as food, clothing, and household supplies; housekeeping services, except for those of a home health aide as prescribed by the plan of care; and transportation services
- Materials such as handrails and ramps
- Services performed by family members and volunteer workers
- Psychiatric care
- Unnecessary and inappropriate services
- Maintenance or [custodial care](#)
- Diversional therapy
- Services or supplies not included in the written treatment plan
- Over-the-counter drugs, solutions, and nutritional supplements
- Dietary assistance, such as Meals on Wheels
- Services provided to someone other than the ill or injured enrollee

Hospice care

In-network: 90%, deductible applies

Out-of-network: 90%, deductible applies

The hospice care benefit allows a terminally ill member to remain at home or to use the services of a hospice center instead of using hospital inpatient services. The plan covers services provided through a state-licensed hospice or other hospice program that meets the standards of the National Hospice Organization. The services must be part of a written treatment plan prescribed by a licensed physician.

This benefit covers visits for intermittent care by a registered nurse (RN) or licensed practical nurse (LPN), a licensed physical or occupational therapist, a certified speech therapist, a certified respiratory therapist or a master of social work. Also included is the cost of a home health aide who acts under the direct supervision of one of the before-mentioned therapists and who is performing services specifically ordered by the member's doctor in the treatment plan. The benefit also includes disposable medical supplies and medications prescribed by the physician, and the rental of durable medical equipment.

In addition, the hospice care benefit covers care in a hospice, and up to 240 hours of respite care for each six-month period of hospice care. The respite care provision allows family members of the terminally ill patient an opportunity to recover from the emotionally and physically demanding tasks of caring for the patient.



Hospice care is a coordinated program of palliative and supportive care for dying members by an interdisciplinary team of professionals and volunteers centering primarily in the member's home.

Intermittent care is care provided due to the medically predictable recurring need for skilled home health care services.

Respite care is continuing to provide care in the temporary absence of the member's primary caregiver or caregivers.

Additional exclusions and limitations for hospice care

In addition to the plan's [Exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- Bereavement or pastoral counseling
- Financial or legal counseling, including real-estate planning or drafting of a will
- Funeral arrangements
- Diversional therapy
- Services that are not related solely to the member, such as transportation, house cleaning, or sitter services

Hospital inpatient care

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers the following inpatient medical and surgical services:

- Room and board, including general duty nursing and special diets
- Use of an intensive care or coronary care unit equipped and operated according to generally recognized hospital standards
- Operating room, surgical supplies, hospital anesthesia services and supplies, drugs, dressings, equipment, and oxygen
- Diagnostic and therapeutic services
- Blood, blood derivatives, and their administration

Regardless of network status, after being treated in the emergency department for an emergent condition and admitted to a hospital inpatient care (as defined by the hospital inpatient care benefit), along with provider charges, will be covered at the in-network level.

For inpatient hospital substance abuse treatment, see the [mental health and chemical dependency](#) benefit.

Additional exclusions and limitations for hospital inpatient care

In addition to the plan's [Exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- Hospital admissions for diagnostic purposes only, unless the services cannot be provided without the use of inpatient hospital facilities, or unless the member's medical condition makes inpatient care medically necessary

- Any days of inpatient care that exceed the length of stay required to treat the member's condition

Hospital outpatient care and ambulatory surgical center care

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers operating, procedure, and recovery rooms; plus services and supplies, such as diagnostic imaging (including X-ray) and laboratory services, X-ray and radium therapy, anesthesia and its administration, surgical dressings and drugs, furnished by and used while at the hospital or ambulatory surgical center.

Infertility

In-network: 90%, deductible applies

Out-of-network: 90% of allowable charges, deductible applies

Limit: up to \$15,000 lifetime benefit maximum per member

This benefit covers services to assist in achieving a pregnancy for Microsoft employees and their enrolled spouse/domestic partner regardless of reason or origin or condition. Covered services include but are not limited to:

- Intrauterine insemination (also known as artificial insemination)
- In vitro fertilization (IVF)
- Gamete intra-fallopian transplant (GIFT)
- Intracytoplasmic sperm injection (ICSI)
- Pre-implantation genetic diagnosis (PGD)
- Services used to preserve fertility such as cryopreservation of eggs, sperm and/or embryos due to infertility or likelihood of future infertility caused by a medical condition that poses a risk to fertility (examples include, but are not limited to: chemotherapy, chronic disease, specific medications, autoimmune issues that impact ovarian function, loss of an ovary or surgery to both ovaries)

Drugs prescribed as part of infertility treatment can be purchased from any retail pharmacy (including an Express Pharmacy) or the Express Scripts Pharmacy by mail home delivery program.

Lifetime benefit maximum

This benefit provides coverage up to a \$15,000 lifetime maximum per member. Drugs used to treat infertility are subject to this benefit's lifetime maximum.

If only one member is involved in the treatment, the cost of the services will count only toward that member's benefit lifetime maximum.

Example

Gerardo and his wife Elyse are trying to conceive. Elyse gets a test of her hormone levels. This test would count toward Elyse's infertility lifetime benefit maximum. A sperm penetration study would count toward Gerardo's infertility lifetime benefit maximum.

Any eligible service, procedure or test performed, drug, or supply that cannot be assigned specifically to either of the participants by using the criteria described above will be assigned to the lifetime benefit maximum of the member whose name appears on the claim submitted for those services.

Additional exclusions and limitations for infertility

In addition to the plan's [Exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- Fees paid to donors for their participation in any service
- Testing and treatment for potential surrogates is not covered other than testing and treatment that would be eligible if provided to a member
- Assisted fertility services, procedures, drugs, or supplies determined to be experimental or investigative
- Any services used to preserve the possibility of fertility except when medical conditions are present that pose particular risk to fertility as noted above

Lab tests

In-network: 90%, deductible applies

Out-of-network: 90% of allowable charges, deductible applies

This benefit covers diagnostic lab tests, including the administration and interpretation, when ordered by a licensed physician.



A pre-service review is recommended for **Genetic Testing** to determine if coverage is available before the service occurs. Either the member or the provider may contact Premera for a pre-service review.

Maternity care

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers maternity benefits provided for you, your enrolled spouse/domestic partner, and your eligible dependent children. Benefits are for maternity care in a hospital, alternative birthing center, or at home, including:

- Prenatal testing when required to diagnose conditions of the unborn child
- Normal deliveries and cesarean sections
- Services of a licensed nurse or midwife
- Miscarriages and terminations of pregnancy
- Hospital nursery care for benefits-eligible infant while the mother is hospitalized and receiving benefits; services are covered under the hospital services benefit
- Male circumcision by a physician or mohel for a benefits-eligible dependent; services are covered under the physician services benefit
- One postpartum home health visit within 30 days of the discharge of the baby from the hospital or alternative birthing center
- Home births include an allowance of up to \$500 for eligible supplies and/or equipment used for home delivery; for example, birthing packs, birthing tubs, monitoring devices, local anesthetics, and comfort aids. Services for the newborn including hospital services and professional services are covered under the hospital services and physician services benefit.

The [home health care](#) benefit covers one postpartum health visit within 30 days of the discharge of the baby from the hospital or alternative birthing center.

Medical equipment and supplies (durable medical supplies)

In-network: 90%, deductible applies

Out-of-network: 90% of allowable charges, deductible applies

Covered services

This benefit covers charges for durable medical and surgical equipment and supplies, (DME). Benefits cover rental or purchase (including shipping and handling fees) of DME for treatment of an injury, illness, disease, or medical condition. Rental equipment will not be reimbursed above the purchase price of the equipment.

Allowed charges to repair or replace covered items are also covered due to a change in the injury, illness, disease, or medical condition, the growth of a child, or when worn out by normal use. Replacement is covered only if needed due to a change in the member's physical condition or if it is less costly to replace than to repair existing equipment or to rent similar equipment.

In order to be covered, DME must be no more than one item of equipment for the same or similar purpose regardless if the plan covered the initial item or not, and the equipment and accessories to operate it must be:

- Made to withstand prolonged use
- Made for and mainly used in the treatment of an injury, illness, disease, or medical condition
- Suited for use in the home

This list of covered DME includes, but is not limited to:

- Braces
- Crutches
- Wheelchairs
- Prostheses
- Foot orthotics (custom fitted shoe inserts) and therapeutic shoes (orthopedic), including fitting expenses, when prescribed by a physician for the condition of diabetes or for corrective purposes
- Wigs (up to \$300 per calendar year for alopecia caused by medical conditions or treatment for diseases)
- Over-the-counter breast pumps intended for use in the home (covered at 100% of allowable charges; deductible does not apply; hospital grade breast pumps are not covered except when used in an inpatient setting)
- Continuous glucose monitors and their supplies will be covered for members with Type 1 Diabetes who are 25 and over. For those under 25 Medical Review would be required.

Vision hardware may be covered under the medical plan for certain medical conditions of the eye, including, but not limited to:

- Corneal ulcer/abrasion
- Bullous keratopathy
- Recurrent erosion of cornea
- Keratoconus
- Tear film insufficiency (dry-eye syndrome)
- Cataract surgery



Certain supplies such as hypodermic needles, test strips and glucose monitors are covered at 100% by the [preventive care](#) benefit.

Additional exclusions and limitations for durable medical and surgical equipment and supplies

In addition to the plan's [Exclusions and limitations](#), the following DME and supplies will not be covered by this plan when they are:

- Normally of use to persons who do not have an injury, illness, disease, or medical condition
- For use in altering air quality or temperature
- For exercise, training and use during participation in sports, recreation, or similar activities
- Equipment, such as whirlpools, portable whirlpool pumps, sauna baths, massage devices, overbed tables, elevators, vision aids, and telephone alert systems
- Equipment or supplies used for treatment of erectile dysfunction
- Special or extra-cost convenience features
- Structural modifications to your home and/or private vehicle
- Replacement of lost or stolen equipment or supplies

Mental health and chemical dependency

Inpatient and Outpatient:

- *100%, up to calendar year visit limits through Microsoft CARES employee assistance program*
- *In-network: 90%, deductible applies*
- *Out-of-network: 70% of allowable charges, deductible applies*

This benefit covers medically necessary treatment for:

- mental health such as, but not limited to the diagnosis and treatment of psychiatric disorders, eating disorders, attention deficit disorder (ADD), attention deficit hyperactivity disorder (ADHD)
- chemical dependency such as substance abuse and alcoholism

To be covered, services must be furnished by an eligible provider.

All mental health and chemical dependency treatment must be medically necessary to be eligible for coverage. Prior authorization is recommended for inpatient care, eligible residential treatment centers, partial hospitalization programs, and intensive outpatient program services. When an emergency admission occurs notification to Premera within two days is also recommended.

Type of care	You will be covered as follows
Through the Microsoft CARES employee assistance program (EAP) as administered by Wellspring Family Services	<ul style="list-style-type: none"> No deductible applies 100% of eligible charges up to calendar year visit limits <ul style="list-style-type: none"> Three visits per member for individual counseling Three telephonic counseling sessions per member for individual counseling Eight visits per family for family or married/domestic partner couples counseling <p>A visit includes each attendance of the provider to the member, regardless of the type of professional services rendered, and whether it might otherwise be termed consultation, treatment, or described in some other manner. For benefit calculation purposes, a typical mental health visit is considered one hour.</p>
Inpatient and Outpatient benefits	<ul style="list-style-type: none"> In-network: 90%, deductible applies; out-of-network: 70% of allowable charges, deductible applies

Eligible providers

Eligible providers include:

- A facility licensed as a hospital or community mental health agency to provide mental health and/or substance abuse services
- A physician, psychiatrist, psychologist, or psychiatric nurse practitioner licensed to provide mental health or substance abuse services
- A master's level mental health provider licensed, registered, or certified as legally required to provide mental health services
- Any other provider or facility who is licensed or certified by the state in which the care is rendered and who is providing care within the scope of their license or certification

Prior Authorization

A prior authorization, also referred to as a pre-service review, is recommended to determine coverage is available before the service occurs. Either the member or the provider may contact Premera for a prior authorization.



A **prior authorization** is an advance determination by Premera that the service is medically necessary and that the member's plan has benefits available for the service being requested. This determination is offered in certain situations where medical records must be provided to establish medical necessity before the plan will pay for the service. Services are subject to eligibility and benefits at the time of service.

The prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition, based on national, evidence-based guidelines. Premera and Microsoft reserve the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

Additional exclusions and limitations for mental health and chemical dependency

In addition to the plan's [Exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- Testing must be ordered by a physician for the purpose of diagnosing or medical management

- Smoking cessation programs or materials; (Microsoft provides a separate Smoking Cessation Program. Prescription drugs for smoking cessation are covered under the prescription drug benefit.)
- Services and supplies that are court-ordered, or are related to deferred prosecution, deferred or suspended sentencing, or driving rights, if those services are not deemed medically necessary
- Educational or recreational therapy or programs; this includes, but is not limited to boarding schools and wilderness programs. Benefits may be provided for medically necessary treatment received in these locations if treatment is provided by an eligible provider.

Nursing care

In-network: 90%, deductible applies

Out-of-network: 90%, deductible applies

This benefit covers skilled care by a registered nurse (RN) or licensed practical nurse (LPN) ordered by a physician. Coverage is for private duty nursing and not nursing that is provided by a home health agency. The nurse who is providing the care cannot be a permanent resident in the member's home.



Skilled nursing care is provided by a registered nurse (RN) or licensed practical nurse (LPN) and the care must require the technical proficiency, scientific skills, and knowledge of an RN or LPN. The need for skilled nursing is determined by the condition of the patient, the nature of the services required, and the complexity or technical aspects of the services provided. Nursing care is not skilled simply because an RN or LPN delivers it or because a physician orders it.

Nutritional therapy

In-network: 100%

Out-of-network: 70% of allowable charges, deductible applies

Limit: First 12 visits per member per calendar year

Additional Visits above the 12

In-network: 90%, deductible applies

Out-of-network 70% of allowable, deductible applies

This benefit covers consultation with a dietician or nutritional therapist or certified lactation consultant for a chronic illness or condition that is impacted by diet and when recommended by the member's physician. The calendar year visit limit is waived and benefits will continue to pay at the same rate for visits over 12 for nutritional therapy received in connection with a diagnosed eating disorder or diabetes.

Illnesses or conditions that would be eligible for this benefit include, but are not limited to:

- Hypertension
- Cardiac problems
- Failure to thrive
- Gastric reflux disease

Physician services

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers:

- Medical and surgical services of a physician
- Urgent care visits at an urgent care facility
- Care via online and telephonic methods when medically appropriate:
 - Benefits for telehealth are subject to standard office visit cost-shares and other provisions as stated in this booklet. Services must be medically necessary to treat a covered illness, injury or condition.
 - Coverage for psychiatric conditions is medically appropriate for crisis and emergency evaluations or when the member is temporarily confined to bed for medical reasons only
- Biofeedback services for any condition covered by the medical benefit when provided by an eligible provider
- Routine foot care when the enrollee is a diabetic
- One initial visit for evaluation of condition otherwise excluded by the contract (for example sexual dysfunction) to exclude medical conditions that could be an underlying cause



An **Urgent care** visit is billed and covered at the same rate as an office visit with your regular physician and is a cost-effective option when you have an urgent need for care. Urgent care is the best option for treatment of a sudden illness, injury or condition that:

- Requires prompt medical attention to avoid serious deterioration of the member's health
- Does not require the level of care provided in the emergency room or a hospital
- Cannot be postponed until the member's physician is available

A **Physician** is a state-licensed:

- Doctor of Medicine and Surgery (M.D.)
- Doctor of Osteopathy (D.O.)

In addition, professional services provided by one of the following types of providers will be treated as physician services under this plan to the extent the provider is providing a service that is within the scope of his or her state license and providing service for which benefits are specified in this plan and would be payable if the service were provided by a physician as defined above:

- Chiropractor (D.C.)
- Dentist (D.D.S. or D.M.D.)
- Optometrist (O.D.)
- Podiatrist (D.P.M.)
- Psychologist (Ph.D.)
- Advanced Registered Nurse Practitioner (A.R.N.P.)
- Nurse (R.N.)
- Naturopathic physician (N.D.)

Prescription drugs

In-network: 90%, deductible applies, up to limits provided below

Out-of-network: 90%, deductible applies, up to limits provided below

This benefit covers most FDA-approved, medically necessary prescription drugs, when prescribed for the member's use outside of a medical facility and dispensed by a licensed pharmacist in a pharmacy licensed by the state in which the pharmacy is located. Also included in this benefit are injectable supplies.

Charges for [infertility drugs](#) over and above the infertility lifetime benefit maximum do not apply to your deductible or coinsurance maximum.



A **prescription drug** is any medical substance that cannot be dispensed without a prescription according to federal law. Only medically necessary prescription drugs are covered by this plan.

Brand-name prescriptions are sold under a trademark name. An equivalent generic drug may or may not be available at lower cost, depending upon whether the patent on the brand-name drug has expired.

Generic drugs are equivalent to brand-name drugs but available at a lower cost than brand-name prescriptions because the patent has expired.

Prescription limits

	Retail pharmacy	Home delivery	Specialty pharmacy
Coverage	<ul style="list-style-type: none"> Up to a 90-day supply for generic maintenance medication; all others are up to a 30-day supply* 	<ul style="list-style-type: none"> Up to 90-day supply* 	<ul style="list-style-type: none"> Up to a 30-day supply* Additional clinical support for members using specialty drugs
In-network pharmacies	<ul style="list-style-type: none"> Express scripts pharmacies bill the plan on your behalf To find an Express Scripts retail pharmacy, call the Premera customer service team at (800) 676-1411 	<ul style="list-style-type: none"> Express scripts pharmacies bill the plan on your behalf 	<ul style="list-style-type: none"> Contracted specialty pharmacies bill the plan on your behalf
Out-of-network pharmacies	<ul style="list-style-type: none"> You will need to submit a prescription reimbursement form, with your receipt, for reimbursement 	<ul style="list-style-type: none"> You will need to submit a prescription reimbursement form, with your receipt, for reimbursement 	<ul style="list-style-type: none"> You will need to submit a prescription reimbursement form, with your receipt, for reimbursement

* Unless the drug maker's packaging limits the supply in some other way.



Generic maintenance medications have a common indication for the treatment of a chronic disease (such as diabetes, high cholesterol, or hypertension). Indications are obtained from the product labeling. They are used for diseases when the duration of the therapy can reasonably be expected to exceed one year.

Specialty drugs are high-cost drugs, often self-injected and used to treat complex or rare conditions, including rheumatoid arthritis, multiple sclerosis, and hepatitis C. Specialty drugs may also require special handling or delivery. These medications can be dispensed only for up to a 30-day supply.



Premera provides a customer service team dedicated to Microsoft employees and their dependents. You can use this service by calling (800) 676-1411 with questions regarding:

- Status of mail order prescriptions
- Plan design, including which medications are covered or not covered
- Location of retail pharmacies

Covered drugs

This benefit covers the following FDA-approved items when dispensed by a licensed pharmacy for use outside of a medical facility. Certain drugs may need a prior authorization:

- Prescription drugs (Federal Legend and State Restricted Drugs as prescribed by a licensed provider). This benefit includes coverage for off-label use of FDA-approved drugs as provided under this plan's definition of prescription drug.
- Compounded medications of which at least one ingredient is a covered prescription drug subject to standard supply limit
- Inhalation spacer devices and peak flow meters
- Glucagon and allergy emergency kits
- Prescribed injectable medications for self-administration (such as insulin)
- Hypodermic needles, syringes, and alcohol swabs used for self-administered injectable prescription medications
- Disposable diabetic testing supplies, including test strips, testing agents, and lancets
- Prescription contraceptive drugs and devices (for example, oral drugs, diaphragms, and cervical caps)
- Infertility drugs; these drugs are covered at the benefit percentages listed for the [infertility](#) benefit and are subject to the infertility lifetime benefit maximum
- Human growth hormone
- Prescription drugs for smoking cessation
- Birth control medications
- Immunization agents and vaccines

Prior Authorization

Prior authorization, also referred to as a pre-service review, is recommended to determine coverage is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.



Prior authorization is an advance determination by Premera that the service is medically necessary and that the member's plan has benefits available for the service being requested. This determination is offered in certain situations where medical records must be provided to establish medical necessity before the plan will pay for the service. Services are subject to eligibility and benefits at the time of service.

Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition based on national, evidence-based guidelines. Premera and Microsoft reserve the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

In order for certain types of drugs to be covered, information from your doctor must be submitted that identifies the disease being treated and explains the role of the drug in the treatment plan to establish its medical necessity. If that information is made available prior to the prescription being filled, and it is determined that the drug is medically necessary, the prescription will be covered as described above. If information for a drug in this category is not provided, you may pay for the prescription to be filled and submit the claim for consideration along with the clinical information. If it is determined that you do not meet medical necessity criteria needed for the drug to be eligible, you will not be reimbursed for the cost of the drug.

Benefits for some prescription drugs may be limited to one or more of the following:

- A set number of days' supply
- A specific drug or drug dose that is appropriate for a normal course of treatment
- A specific diagnosis
- Be under the care of an appropriate medical specialist
- Trying a generic drug or a specified brand name drug first

In making these determinations, Premera takes into consideration clinically evidence-based medical necessity criteria, recommendations of the manufacturer, the circumstances of the individual case, U.S. Food and Drug Administration guidelines, published medical literature and standard reference compendia.



For questions about your pharmacy benefits or quantity limits, please contact Premera Customer Service at (800) 676-1411.

The table below provides information on how to submit information for a medical necessity review.

Drug	Information
Impotence medication resulting from a secondary condition	Send clinical information about condition being treated to Express Scripts Home Delivery by mail with the prescription for the drug. If covered, supplies are limited to a maximum of 45 pills every 90 days.
Certain drugs require a review. Examples include: rheumatoid arthritis, certain cancer treatment drugs, growth hormones, anti-depressants, corticosteroid nasal sprays, diabetes, migraine therapy, multiple sclerosis and compound medications.	Have your provider call (888) 261-1756 to start or update the benefit review process for these or other drugs needing clinical review. If you would like to find out if your drug requires review call Premera Customer Services at (800) 676-1411.



Categories of drugs on this list may be added or deleted from time to time, based on factors including FDA-approval status, medical necessity, member safety, and best practices. If you have paid for a prescription of a drug in this category, you may appeal any denial of benefits for that drug through the appeals process.

Drug-usage patterns

The plan may be provided with information from a variety of sources regarding drug-usage patterns of individual members that merit further investigation. If the conclusion of the investigation is that the drug-usage patterns are not consistent with generally accepted standards of practice, the plan may choose to restrict access to the benefit to one prescribing physician for those members. If this action is taken, the member will be notified in advance.

Your right to safe and effective pharmacy services

State and federal laws establish standards to assure safe and effective pharmacy services, and to guarantee your right to know what drugs are covered under this plan and what coverage limitations are in your contract.



If you want more information about the drug coverage policies under this plan, or if you have a question or a concern about your pharmacy benefit, call the Premiera customer service team at (800) 676-1411.

If you have a concern about the pharmacists or pharmacies serving you, call your State Department of Health.

Additional exclusions and limitations for prescription drugs

In addition to the plan's [Exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- Drugs and medications not approved by the Food and Drug Administration (FDA) except as defined in the Experimental and Investigational section
- Drugs and medicines that may be lawfully obtained over the counter (OTC) without a prescription. OTC drugs are excluded even if prescribed by a practitioner, unless otherwise stated in this benefit. These may include, but are not limited to: nonprescription drugs and vitamins, food and dietary supplements, herbal or naturopathic medicines, and nutritional and dietary supplements (for example, infant formulas or protein supplements). This exclusion does not apply to emergency contraceptive methods (such as "Plan B"), aspirin for men and women, folic acid for women and iron supplements.
- Over-the-counter female contraceptive methods and supplies (for example, jellies, creams, foams, female condoms or devices) without a prescription even if used in conjunction with covered equipment or supplies, and all male contraceptives
- Drugs for the purpose of cosmetic use (for example, promote or stimulate hair growth, stop hair loss, or prevent wrinkles)
- Growth hormone for the diagnosis of idiopathic short stature (ISS), familial short stature (FSS), or constitutional short stature (CSS)
- Drugs for experimental or investigative use
- Any prescription refilled too soon or in excess of the number of refills specified by the prescribing provider, or any refill dispensed after one year from the prescribing provider's original order
- Replacement of lost or stolen medication
- Drugs to treat infertility are subject to limits and maximums of that benefit
- Drugs used for impotence except as listed under the Covered Drugs In Need of Clinical Information from your Doctor for Medical Necessity Review section
- Devices and appliances, support garments, and non-medical supplies
- Drugs used for weight loss or weight management
- This plan does not cover the cost of drugs that are reimbursed under another plan or another portion of your Microsoft coverage (for example, drugs administered while hospitalized)
- Charges for prescription drugs when obtained through an unauthorized pharmacy or provider when a restriction of the prescription drug benefit is in place

Preventive care

Preventive services:

- *In-network: 100%*
- *Out-of-network: 70% of allowable charges, deductible applies; well-child care through age 6 is covered at 100%*

This benefit covers routine exams, immunizations and health screenings, such as:

- Routine physicals for men and women
- Woman's preventive care including a gynecological exam, routine pap smear and routine mammogram
- Well-child exams, including physical exams, tests, and immunizations, through age 11 and annual physical exams for age 12 through 18
- Hearing screening for children through age 18
- Routine eye exams
- Flu shots
- Cancer screenings
- Immunizations, which need not be done at the same time as the routine exam

For individuals with known risk factors, such as family history of a disease with known hereditary links, the limits in the recommended guidelines for preventive screenings may not be applicable.



For a complete list of what is considered preventive care and paid 100% by the plan, see the [Preventive Care Services list](#), or contact Premera Customer Service at (800) 676-1411.

Rehabilitation

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers physical therapy, functional occupational therapy, and speech therapy services to:

- Restore and improve a bodily or cognitive function that was previously normal but was lost after an accidental injury or illness
- Treat disorders or delays in the development of language, cognitive, or motor skills

Inpatient services are covered when services cannot be rendered in any other setting. Outpatient services are limited to a maximum of one hour of each specialty (physical therapy, occupational therapy and speech therapy) per day.

Physical therapy, functional occupational therapy, and speech therapy are covered when rendered by a physician or by a licensed or registered physical or occupational therapist or a certified speech therapist that is licensed or registered as required as such by the state in which he or she practices.

Services rendered by a massage therapist are not covered under the rehabilitation benefit. Please refer to the Chiropractic services, acupuncture, and medical massage therapy benefit for coverage.

Respite Care

In-network: 90%, deductible applies

Out-of-network: 90%, deductible applies

Limit: 240 hours per calendar year

Respite care is for covered members who need assistance with activities of daily living (ADLs) such as bathing and dressing due to a permanent or temporary disabling medical condition, such as a traumatic brain injury, advanced multiple sclerosis, and severe cerebral palsy, where the member needs assistance moving from one place to the other. This benefit covers 240 hours per calendar year in the member's residential home to provide

family caregivers an opportunity to recover from the emotionally and physically demanding tasks of caring for the covered member who requires assistance with ADLs

The respite care application form and a home assessment must be completed prior to accessing this benefit. After the home assessment, Premera will make a determination if the covered member needs assistance with ADLs related to a disabling medical condition and qualifies for respite care coverage, which may be approved for up to a 12-month period. The home assessment is covered under the [Home health care](#) benefit. For the respite care application and more information on this benefit, please call Premera Customer Service at 800-676-1411.

Additional exclusions and limitations for respite care:

In addition to the plan's [Exclusions and Limitations](#), the following exclusions and limitations apply to this benefit:

- Respite care provided by a non-certified or non-licensed provider or agency
- Respite care provided by a family member or friend
- Travel expenses, mileage, supplies or any other personal needs of the provider of the respite care
- Instrumental ADLs – examples of instrumental ADLs that are not covered by this benefit include, but are not limited to: shopping, housework, managing finances and using the computer.

Skilled nursing facility

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

Limit: up to 120 days per member per calendar year

This benefit covers inpatient care in a Medicare-approved skilled nursing facility for up to 120 days in each calendar year. Services must be part of a formal written treatment plan prescribed by the doctor. Custodial care is not included in this coverage.



Custodial care is provided primarily for ongoing maintenance of a person's condition or to assist a person in meeting activities of daily living, and not for therapeutic value or requiring the constant attention of trained medical personnel. Review the [glossary](#) for a full definition.

Services and supplies eligible for reimbursement include:

- Room and board, meals, and general nursing care
- Services and supplies furnished and used while you are in the skilled nursing facility, such as:
 - The use of special treatment rooms
 - Routine lab exams
 - Physical
 - Occupational or speech therapy
 - Respiratory and other gas therapy
 - Drugs and biologicals (such as blood products and solutions)
 - Gauze, cotton, fabrics, solutions, plaster, and other materials used in dressings and casts

Additional exclusions and limitations for skilled nursing facility

In addition to the plan's [Exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- Custodial care is not provided
- Care that is primarily for senile deterioration, mental deficiency, or retardation, or the treatment of substance abuse and alcoholism

Sterilization services**Elective Sterilization – Female**

In-network: 100%

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers elective, permanent sterilization procedures, such as tubal ligation. Reversals or attempted reversals of these procedures are not covered.

Elective Sterilization – Male

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers elective, permanent sterilization procedures, such as vasectomy. Reversals or attempted reversals of these procedures are not covered.

Surgical weight loss treatment

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers you, your spouse/domestic partner, or dependent when the criteria listed in the Premera Medical Policy on Bariatric Surgery are met.



Contact Premera at (800) 676-1411 for a copy of the policy.

Who is eligible

Examples of qualifying criteria include:

- A Body Mass Index (BMI) greater than 40 Kilograms (kg) per square meter (m2) or BMI greater than 35 Kg per m2 in conjunction with severe diabetes, hypertension, or obstructive sleep apnea
- Physician-supervised weight reduction program which includes:
 - A program of at least six consecutive months in duration, within the two-year period prior to surgery being considered.
 - Evidence of active participation in a program documented in the member's medical records

Prior Authorization

Prior authorization, also referred to as a pre-service review, is recommended to determine coverage is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.



Prior authorization is an advance determination by Premera that the service is medically necessary and that the member's plan has benefits available for the service being requested. This determination is offered in certain situations where medical records must be provided to establish medical necessity before the plan will pay for the service. Services are subject to eligibility and benefits at the time of service.

Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition based on national, evidence-based guidelines. Premera and Microsoft reserve the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

Temporomandibular joint (TMJ) dysfunction

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers treatment of temporomandibular joint (TMJ) dysfunction and other related disorders, such as myofascial pain dysfunction (MPD). Services must be rendered by a physician, hospital, licensed or registered physical therapist, or licensed dentist.



For TMJ services, pre-service review requests should be faxed to Dental Review at (425) 918-5956 or mailed to:

Dental Review
MS 173
P.O. Box 91059
Seattle, WA, 98111-9159

TMJ services and supplies for the treatment of TMJ dysfunction and myofascial pain dysfunction include:

- Diagnostic and follow-up examinations
- Diagnostic X-ray services
- Oral surgery
- Physical therapy
- Biofeedback
- Transcutaneous Electrical Nerve Stimulation (TENS)
- TMJ splints or TMJ guards

Transfusions, blood, and blood derivatives

In-network: 90%, deductible applies

Out-of-network: 90%, deductible applies

This benefit covers transfusions, blood, and blood derivatives that are not replaced by voluntary donors. The cost of donating and storing your own blood for a planned surgery is also covered.

Transgender services

In-network: 90%, deductible applies

Out-of-network: 90% of allowable charges, deductible applies

This benefit covers medically necessary transgender surgical services, including facility and anesthesia charges related to the surgery.

Coverage of prescription drugs and mental health treatment associated with gender reassignment surgery is available under the [prescription drugs](#) and [mental health](#) benefits.

Who is eligible

Surgical gender reassignment services will be considered medically necessary and covered if all the following criteria are met:

- For all surgical procedures recognized as medically necessary in the most current Standards of Care published by the World Professional Association for Transgender Health (WPATH), other than genital and breast surgery; benefits are available if you are at least 18 years old and diagnosed as having gender dysphoria
- For breast/chest surgery you must meet the above and have one letter of recommendation for surgery from a mental health professional
- For genital surgery you must meet the first criteria and the following criteria as well:
 - You have been an active participant in a recognized gender identity treatment program and have successfully lived and worked within the desired gender role full time for at least 12 months
 - You have received recommendations for surgery from two separate mental health professionals, at least one of which includes an extensive report. One Master's degree-level professional is acceptable if the second letter is from a psychiatrist or PhD clinical psychologist.

Prior Authorization

Prior authorization, also referred to as a pre-service review, is recommended to determine coverage is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.



Prior authorization is an advance determination by Premera that the service is medically necessary and that the member's plan has benefits available for the service being requested. This determination is offered in certain situations where medical records must be provided to establish medical necessity before the plan will pay for the service. Services are subject to eligibility and benefits at the time of service.

Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition based on national, evidence-based guidelines. Premera and Microsoft reserve the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

For transgender services, the prior authorization should include:

- The surgical procedure(s) for which coverage is being requested
- The date the procedure will be performed
- Information supporting that the criteria listed above have been met, based on the surgery being requested



Your physician can fax this information to (800) 843-1114 or mail it to:

Premera Blue Cross
Attn: Integrated Health Management
P.O. 91059

Seattle, WA
98111-09159

Transplants

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

This benefit covers solid organ transplants and bone marrow/stem cell reinfusion—procedures cannot be experimental or investigative.



Experimental or investigational services, equipment, and drugs have not been approved by the U.S. Food and Drug Administration (FDA) for the specified use. Review the [glossary](#) for a full definition.



The transplant benefit doesn't cover cornea transplantation, skin grafts, or the transplant of blood or blood derivatives (except for bone marrow or stem cells). These procedures are covered on the same basis as any other covered surgical procedure.

Eligible providers

To be eligible for coverage, the transplant or reinfusion must be furnished in an approved transplant center that has developed expertise in performing solid organ transplants, bone marrow reinfusion, or stem cell reinfusion, and is approved by Premera. Premera has contractual agreements with approved transplant centers, and has access to a special network of approved transplant centers, throughout the United States. Whenever medically possible, we will direct you to an approved transplant center with which Premera has a contract. Of course, if neither a Premera-approved transplant center nor a Premera network transplant center can provide the type of transplant you need, this benefit will cover a transplant center that meets the approval standards that are set by Premera.



Approved transplant center is a hospital or other provider that has developed expertise in performing covered transplant services and has a contractual agreement in place with Premera. Review the [glossary](#) for a full definition.

Donor costs

All donor acquisition costs such as selection (testing and typing), harvesting (removal) transportation of donor organ, bone marrow and stem cells, and storage costs for bone marrow and stem cells for a period of up to 12 months are covered services, including costs incurred by the surgical harvesting teams.

Expenses for transportation, lodging, and meals

Expenses for transportation, lodging, and meals for the transplant recipient (while not confined) and one companion, except as stated below, are covered but limited as follows:

- The transplant recipient must reside more than 50 miles from the approved transplant center unless the treatment protocols are medically necessary and require the member to remain closer to the transplant center

- The transportation must be to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure, or post-discharge follow-up
- When the recipient is a dependent minor child, benefits for transportation, lodging, and meal expenses for the recipient and two companions will be provided at 100% (deductible applies), up to a maximum of \$125 per day
- When the recipient is not a dependent minor child, benefits for transportation, lodging, and meal expenses for the recipient and one companion will be provided at 100% (deductible applies), up to a maximum of \$80 per day

Additional exclusions and limitations for transplants

In addition to the plan's [Exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- Nonhuman or mechanical organs, unless they are not experimental or investigative
- Services and supplies that are payable by any government, foundation, or charitable grant. This includes services performed on potential or actual recipients or donors (living or cadaver).
- Donor costs are not covered if the recipient of the transplant service is not a Microsoft enrollee. This applies to donor costs for all types of transplant services, solid organ and bone marrow or stem cell reinfusion.
- Donor costs are not covered by Microsoft if benefits are available under other group or individual coverage
- Donor costs are not covered for transportation for typing or matching

Vision therapy

In-network: 90%, deductible applies

Out-of-network: 70% of allowable charges, deductible applies

Limit: up to 32-visit lifetime benefit maximum

This benefit covers vision training, eye training or eye exercises up to a lifetime benefit maximum of 32 treatment visits for the following conditions only:

- Amblyopia
- Convergence insufficiency
- Esotropia or exotropia

All other uses of vision therapy are considered investigative and are not covered. Vision therapy is not a covered service under the [Vision plan](#). Costs of equipment and supplies associated with vision therapy are not covered.

Weight Management program

In-network: 80%, up to \$6,000 lifetime benefit maximum, deductible and coinsurance maximum does not apply

Out-of-network: not applicable

This benefit covers comprehensive and clinically based weight management programs for the treatment of obesity. The 20% coinsurance you pay will not count toward the deductible or coinsurance maximum and will continue after the deductible and coinsurance are met.

Who is eligible

Members are eligible for this benefit if they meet the following criteria:

- Diagnosed as obese (commonly Body Mass Index (BMI) greater than or equal to 30)

- Overweight with a BMI greater than or equal to 27, and diagnosed with two or more of the following conditions:
 - Congestive heart failure
 - Coronary heart disease
 - Depression
 - Diabetes
 - Hyperlipidemia
 - Hypertension

Dependent children are not eligible for this benefit.

Eligible providers

Approved weight management providers of this benefit must meet eligibility requirements set forth by Microsoft and Premera and be providing services under a weight management program that is contracted for and approved by Premera for this plan.

Approved weight management programs will be those programs that are comprehensive and clinically based. Approved programs must be based on medical oversight and include treatment from professionals in the areas of nutrition, behavioral therapy, and personal training. An approved program must include an initial minimum 10-week period of frequent sessions with the program's physician, personal trainer, dietician, and behavioral therapist. This initial period must be followed by a minimum three-month maintenance period, which includes regular follow-up visits with these program professionals.

The Weight Management program must be contracted for and approved by Premera both at the time the participant or covered spouse/domestic partner begins the program and when he or she completes the program. If the program is not approved and contracted for until after the participant has started treatment under the program, no part of the cost of the program will be covered under this benefit.



To find an approved provider, review the [Weight Management providers list](#).

Prior Authorization

Prior authorization, also referred to as a pre-service review, is recommended to determine coverage is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.



Prior authorization is an advance determination by Premera that the service is medically necessary and that the member's plan has benefits available for the service being requested. This determination is offered in certain situations where medical records must be provided to establish medical necessity before the plan will pay for the service. Services are subject to eligibility and benefits at the time of service.

Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition based on national, evidence-based guidelines. Premera and Microsoft reserve the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

A [Weight Management Recommendation form](#) or confirmation of your BMI and co-morbid conditions should be submitted to Premera prior to receiving reimbursement from Premera. Your physician's recommendation will confirm you meet the contract criteria required for this benefit to be available.

The following are the steps that must be completed to ensure that your treatment meets the criteria of this benefit:

1. Take the Weight Management Recommendation form to your regular physician
2. An evaluation is performed by your physician to determine if you meet the eligibility requirements set forth above
3. Your physician faxes or mails the Weight Management Recommendation Form to Premera Care Facilitation to confirm that you meet the weight management eligibility requirements and your physician's approval



Your physician can fax this information to (800) 866-4198 or mail it to:

Premera Blue Cross
Attn: Care Facilitation
P.O. 91059
Seattle, WA 98111-9159

4. Premera will review the information submitted and verify the coverage through a prior authorization

Participation in the program should begin within six months of the prior authorization being issued or a new prior authorization will need to be requested.

Claims payment

Final claims payment will be contingent on Premera receiving all biometric reporting information for the participant. Reimbursement for this benefit may occur in one of two ways. The program you attend will select the claims payment method used.

Method 1: Direct reimbursement to member

The provider will bill you directly for services provided. The frequency of billing should be made clear by the provider before you start the program. The weight management provider may collect a deposit from you to initiate your participation in the program.

During the course of the program you can submit an interim weight management billing claim form on a monthly or quarterly basis to Premera for reimbursement. You may also submit a final weight management billing claim form at the end of the program.

If your coverage terminates during the time you are participating in an approved program, and you do not elect COBRA, only services rendered up to the date of termination of coverage will be reimbursed.

Method 2: Direct reimbursement to provider

Reimbursement will be made directly to the weight management provider on a monthly or quarterly basis. The weight management provider may collect a deposit from you to initiate your participation in the program, but will bill Premera on a monthly or quarterly basis for your ongoing participation.

Additional exclusions and limitations for Weight Management program

In addition to the plan's [Exclusions and limitations](#), the following exclusions and limitations apply to this benefit:

- Food
- Nutritional supplements (i.e., protein shakes)
- Drugs or surgical procedures to assist in reducing weight or curbing hunger

X-rays

In-network: 90%, deductible applies

Out-of-network: 90% of allowable charges, deductible applies

This benefit covers diagnostic X-rays, including the administration and interpretation, when ordered by a licensed physician.

Exclusions and limitations

- Services or supplies not medically necessary for diagnosis, care, or treatment of a disease, illness, injury, or medical condition, except for the following: (a) newborn nursery care covered under the hospital benefit; (b) male circumcision benefit; (c) sterilization benefit; (d) termination of pregnancy benefit; (e) infertility benefit; (f) hospice care benefit; and (g) well-child care and adult physical exam benefits
- Charges in excess of eligible charges, including out-of-network provider billed amounts over the allowable charges
- Expenses in excess of the applicable annual and lifetime benefit maximums
- Services for which claim was not received by Premera within 12 months of the date of service. Corrected claims and COB claims need to be submitted within 12 months from the original claim submission date.
- Over-the-counter drugs (unless prescribed), food dietary supplements (for example, infant formulas or protein supplements), herbal or naturopathic/homeopathic medicine are not covered
- Over-the-counter (OTC) testing and supplies (for example, OTC pregnancy test and ovulation tests) except as covered under the DME benefit
- Charges for or in connection with services or supplies that are determined to be experimental or investigational
- Benefits that overlap or duplicate benefits for which the member is eligible under any other group benefit plan; Workers' Compensation or similar employee benefit law; Medicare A or B; or government-sponsored program of any type
- Services or supplies that are covered through any type of no-fault coverage or similar type of insurance coverage or contract, including boat policies, motor vehicle, Personal injury protection (PIP), Medical payments (MEDPAY), Medical Premise for homeowners or commercial (MEDPREM) or excess medical coverage
- Work-related Conditions: This exclusion applies whether or not a proper or timely claim for benefits has been made under the following programs. This plan does not cover services or supplies for which you are entitled to receive benefits under:
 - Occupational coverage required of, or voluntarily obtained by, the employer
 - State or Federal workers' compensation acts
 - Any legislative act providing compensation for work-related illness or injury

- In the event that you do not comply with the contractual terms of subrogation, the plan will no longer be obligated to provide any benefits under this plan. The plan has the right to deduct the amount of benefits paid from any future benefits payable to the enrollee or to any other covered dependent.
- Any services or supplies for which no charge is made, or for which a charge is made because this plan is in effect, or for services or supplies for which the member is legally liable because this plan is in effect
- Services of a social worker except as provided in the hospice care benefit, the home health care benefit and the mental health, substance abuse, and alcoholism treatment benefit
- Routine or palliative foot care to treat fallen arches, flat feet, care of corns, bunions (except for bone surgery), calluses, toenails (except for ingrown toenail surgery) and other problems that are commonly treated with off-the-shelf, over-the-counter (OTC) therapy. This exclusion does not apply to enrollees who are diabetic.
- Foot or shoe prosthetics, appliances, orthotics or inserts except as described under the durable medical and surgical equipment and supplies benefit. This does not apply to enrollees who are diabetic.
- Massage therapy that is not medically necessary and without a prescription
- Hearing exams, hearing aids, services for mental conditions, substance abuse, alcoholism, cosmetic services, organ, bone marrow, and stem cell transplants, infertility, vision therapy, and surgical weight loss treatment, except as provided under the specific benefits for these conditions
- Liquid diets or fasting programs, memberships in diet programs or health clubs, or wiring of the jaw
- Drugs and medications not approved by the Food and Drug Administration (FDA) except as defined in the Experimental and Investigational section
- Procedures for sterilization reversals
- Hypnotherapy, regardless of provider
- Hippotherapy or other forms of equine or animal-based therapy
- Electronic services and/or consults, except as covered under the physicians' benefit
- Services or supplies furnished by a member to himself or herself or by a provider who is in any way related to the member. This also includes covered dependents under the plan who are living within the member's household.
- Services that are outside the scope of the provider's license or certification, or that are furnished by a provider that is not licensed or certified by the jurisdiction in which the services or supplies were received
- Separate charges for records or reports, except those Premera requests for utilization review
- Voluntary support or affinity groups such as patient support, diabetic support groups or Alcoholics Anonymous. Additionally, volunteer services or services provided by or through a school, books, and other training aids are also not covered.
- Non-treatment facilities, institutions or programs: Benefits are not provided for institutional care, housing, incarceration or programs from facilities that are not licensed to provide medical or behavioral health treatment for covered conditions. Examples are prisons, nursing homes, juvenile detention facilities, group homes, foster homes and adult family homes. Benefits may be provided for medically necessary treatment received in these locations if treatment is provided by an eligible provider.
- Services or supplies for any of the following:
 - Education and training programs including testing or supplies/materials, including vision training supplies
 - Educational or recreational therapy or programs; this includes, but is not limited to boarding schools and wilderness programs. Benefits may be provided for medically necessary treatment received in these locations if treatment is provided by an eligible provider.
 - Social, cultural, or vocational rehabilitation or vision training supplies

- Sexual dysfunction disorders and/or defects, whether or not the consequence of illness, disease, or injury, such as impotence, frigidity, or sexual addiction, except as specified in the [cosmetic and reconstruction surgery](#) benefit or the [prescription drug](#) benefit
- Refractive surgery of the eye (surgery to improve vision that can be corrected with glasses or contact lenses) is covered only as specified under the vision plan
- Over-the-counter breast pumps intended for use in the home will be covered at 100% of allowable charges; deductible does not apply; however, hospital grade breast pumps are not covered except when used in an inpatient setting
- Services for individuals not eligible for coverage under the Microsoft Plan will not be reimbursed except in the following circumstances:
 - Donors for organ or bone marrow/stem cell transplantation for services specific to that procedure
 - Testing and treatment of infertility performed on surrogates when the same services would be covered if performed on member; testing and treatment for selection of a surrogate or potential surrogates is not covered
 - Genetic testing of relatives when the information is needed to adequately assess risk in the member; the result of the test will directly impact the treatment to the member; and there is no other coverage available to the relative
- Lodging is covered only as outlined in the transplant benefit
- When Coordinating Benefits (COB) and you fail to follow the rules of the primary plan, this plan would pay nothing for that expense
- Benefits are not provided for services or supplies (1) for which no charge is made, (2) for which no charge would have been made if this plan were not in effect or (3) that were not received by the member while covered by the plan
- Services received in excess of a benefit limit or maximum are not covered. Any network discounts for in-network providers do not apply to services received in excess of the benefit limit.

In addition, certain exclusions and limitations apply to the following benefits. CTRL+Click to navigate to the benefit information.

- [Autism/ABA therapy](#)
- [Dental services](#)
- [Hearing care and hardware](#)
- [Home health care](#)
- [Hospice care](#)
- [Hospital inpatient care](#)
- [Infertility](#)
- [Medical and surgical equipment and supplies](#)
- [Mental health and chemical dependency](#)

- Prescription drugs
- Skilled nursing facility
- Transplants
- Weight Management program

How to file a claim

In most cases, when you receive care from an in-network provider, your provider will submit bills directly to Premera, and this submission is your claim for benefits. If your provider does not submit a bill directly to Premera, you will need to submit a claim for benefits.

If possible, you should submit the claim form within 30 days of the service. The plan will not reimburse claims submitted more than 12 months after the date of service.

To submit a claim:

1. Download the [Premera claim form](#) or e-mail Premera at microsoft@premera.com to request a claim form
2. Complete the claim form, including all of the following information:
 - a. Your name and the member's name
 - b. Identification numbers shown on your identification card (including the alpha 3-digit, or MSJ)
 - c. Provider's name, address, and tax identification number
 - d. If you are seeking secondary coverage from the Microsoft health plan, information about other insurance coverage related to the claim at hand, including a copy of their Explanation of Benefits (EOB), if applicable
 - e. If treatment is as a result of an accident: the date, time, location and brief description of the accident
 - f. Date of onset of the illness or injury
 - g. Date of service
 - h. Diagnosis or ICD-10 (this information can be found on the provider bill)
 - i. Procedure codes (CPT-4, HCPCS, ADA, or UB-92) or descriptive English language for each service (this information can be found on the provider bill)
 - j. Itemized charges for each service rendered by provider
3. Sign the form in the space provided and attach the itemized provider bill
4. Mail the completed form to:

Premera Blue Cross
 P.O. Box 91059
 Seattle, WA 98111-9159
 Fax (800) 676-1477
 Email for claims: Microsoft@premera.com



COBRA-eligibility claims should be submitted as described in the [Continuation of coverage for health benefits](#) section.

In the following circumstances, you may submit claims according to the [appeals process](#):

- *If you cannot submit the claim in a timely manner due to circumstances beyond your control*
- *If your claim regards plan eligibility for you, your spouse/domestic partner, or dependent child*

Claim review and payment

Premera will send you an Explanation of Benefits (EOB) or other communication notifying you of their decision on your claim no more than 30 days after Premera receives the claim. Premera may extend this 30-day period for up to 15 days if the extension is required due to matters beyond the control of Premera.



Explanation of benefits (EOB) is the statement you receive from Premera Blue Cross detailing how much the provider billed, how much (if any) the plan paid, and the amount that you owe the provider (if any).

You will have at least 45 days to provide any additional information requested of you by Premera, if an extension is required due to Premera needing additional information from you or your health care providers.

Premera will make a payment to the employee, a dependent (age 13 or older), a provider, or another carrier. Payments are subject to applicable law and regulation:

- Premera may make payments on behalf of an enrolled child to a non-enrolled parent or state agency to which the plan is required by applicable law to direct such payments
- Payments made will discharge the plan to the extent of the amount paid, so that the plan is not liable to anyone due to its choice of payee

Denied claims notice

If all or part of your claim is denied, Premera will send you an Explanation of Benefits (EOB) or other notice with the following information:

- The specific reason or reasons for the denial
- Reference to the specific plan provisions on which the denial is based
- A description of any additional material or information needed from you and the reason it is needed
- An explanation of the appeals procedures and the applicable time limits
- A statement regarding any internal rule, guideline, protocol or other criterion that was relied upon in making the adverse determination (a copy of which will be provided free upon request)
- If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment that led to this determination (a copy of which will be provided free upon request)
- If the claim is an urgent care claim (as defined under law), a description of the expedited review process applicable to such claims
- If you have filed a claim with Premera relating to plan eligibility, and this claim is denied, Premera will send you a notice explaining your appeal rights
- Notice regarding your right to bring legal action following a denial on appeal

For medical and transplant benefits, the denial will also include:

- Information sufficient to identify the claim involved, including the date of service, health care provider and claim amount, if applicable
- The denial code and its meaning

- A description of the plan's standard for denying the claim
- Information regarding available internal and external appeals, including how to initiate an appeal
- Contact information for Premera Customer Service or the Employee Benefits Security Administration (EBSA) of the U.S. Department of Labor to assist participants with the internal and external appeals process

Appeal for internal review

If the plan denies your claim, you may appeal for an internal review of the decision within 180 days of receiving the Explanation of Benefits (EOB).



An **appeal** is a written request to reconsider a written or official verbal adverse determination to deny, modify, reduce or end payment, coverage or authorization of health care coverage or eligibility to participate in the plan. This includes admissions to and continued stays in a facility. The process also applies to Flexible Spending Account appeals for reimbursement but does not apply to appeals of denied COBRA eligibility claims.



If you fail to file the internal appeal within 180 days of receiving the Explanation of Benefits, you will permanently lose your right to appeal the denied claim.

Submitting an appeal for internal review

You or your authorized representative must provide the following information as part of your written appeal to the Premera Appeals Department.

- Your name
- Your Premera member number
- The name of this plan, and
- A concise statement of why you disagree with the decision, including facts or theories supporting your claim

Your written request may (but is not required to) include issues, comments, documents, and other records you want considered in the review.



The appeal should be submitted to Premera at the following address:

Appeals Coordinator
Premera Blue Cross
P.O. Box 91102
Seattle, WA 98111-9202

You may, at your own expense, have a representative act on your behalf. If you want to appoint someone to act for you in the appeals process (including your provider), you must submit a completed and signed [Premera Internal Appeals Authorization form](#) with your written appeal for internal review to the appeals coordinator at the address above.

In the case of an urgent care appeal, you may submit your appeal request in writing and all necessary information may be transmitted between you and the plan by fax. If your provider believes your situation is urgent as defined under law and so notifies Premera, your appeal will be conducted on an expedited basis. Notification will be furnished to you as soon as possible, but not later than 72 hours after receipt of the expedited appeal. Your appeal should clearly indicate your request for an expedited appeal.

For urgent situations or if you are in an ongoing course of treatment you may begin an external independent review at the same time as Premera Blue Cross's internal review process. The external review agency is not legally affiliated or controlled by Premera. The external review agency decision is final and is generally binding upon the Plan.



To file an urgent care appeal request, you may fax a request to (425) 918-5592.



The external review for non-urgent situations is available only after you have properly exhausted the internal appeal as described above.



An urgent situation means one in which your provider concludes that the application of the standard time periods for making determinations could seriously jeopardize your life or health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

The new definition of urgent is as follows:

If your provider believes the situation meets the definition of urgent under the law and we agree, your review will be conducted on an expedited basis. If you are currently in the hospital, you have the right to an expedited appeal and we will review your case and provide you with a decision within 24-72 hours.

We will not expedite your appeal if you have already received the services you are appealing, or if you do not meet the above requirements.

Internal review and timeframe

All the information you submit will be taken into account on appeal, even if it was not reviewed as part of the initial decision. You may ask to examine or receive free copies of all pertinent plan documents, records, and other information relevant to your claim by requesting these from Premera.

The plan may consult with a health care professional who has experience in the field of medicine involved in the medical judgment to decide your appeal. You may request the identity of medical experts whose advice was obtained by the plan in connection with your initial claim denial, even if their advice was not relied upon in making the initial decision.

In the event any new or additional information (evidence) is considered, relied on or generated by Premera in connection with your appeal, Premera will provide this information to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Premera, Premera will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that that you will have an opportunity to respond.

If you have not had the service yet these are considered pre-service appeals and we will send a decision no later than 30 calendar days after receipt of your appeal request.

If you have already had the service these are considered post service appeals, we will send a decision no later than 60 calendar days after receipt of your appeal request.

Denied appeal notice

If your appeal is denied, you will receive a written notice setting forth:

- The specific reason or reasons for the denial
- Reference to the specific plan provisions on which the denial is based
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits
- A statement explaining the external review procedures offered by the plan and your right to bring a civil action under ERISA section 502(a)
- A statement regarding any internal rule, guideline, protocol or other criterion that was relied upon in denying the claim (a copy of which will be provided free upon request)
- If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment that led to this determination (a copy of which will be provided free upon request)

For medical and transplant benefits, the denial will also include:

- Information sufficient to identify the claim involved, including the date of service, health care provider and claim amount, if applicable
- The denial code and its meaning
- A description of the Plan's standard for denying the claim
- Information regarding available internal and external appeals, including how to initiate an appeal
- Contact information for Premiera Customer Service or the Employee Benefits Security Administration (EBSA) of the U.S. Department of Labor to assist participants with the internal and external appeals process

Appeal for external review

If you are not satisfied with the final internal denial of your claim, you may request an external review by an independent review organization (IRO) if that denial is based on medical judgment including:

- Requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit
- A determination that a treatment is experimental or investigational



An **independent review organization (IRO)** is an independent organization of medical experts who are qualified to review medical and other relevant information.

The external review for non-urgent situations is available only after you have properly exhausted the internal appeals process as described above. There are no fees or costs imposed on you as part of the external review.

The external review agency decision is final and is generally binding upon the plan.

Submitting an appeal for external review

An [External Review Request form](#) will be sent with your internal appeal determination letter notifying you of your rights to an external review.

To initiate the external review, you must complete and sign the form and send it to Premera at the address below no later than 120 days after the date you receive your internal appeal determination letter, which the plan deems to be seven days after the date on the internal appeal determination letter.



If you fail to submit the completed and signed form within this timeframe, you will permanently lose your right to an external review.



Mail the External Review Request form to:

Premera Blue Cross
Attn: Microsoft Member Appeals – IRO Mail Stop 123
P.O. Box 91102
Seattle, WA 98111-9202

External review and timeframe

If your appeal is eligible for external review, Premera will notify the IRO of your request for an external review and send them all the information included in your internal appeal and other relevant materials within six days of receipt.

The IRO will contact Premera directly if additional information is needed. Premera will provide the IRO with any additional information they request that is reasonably available. The external review request is considered complete when the IRO has all the requested information and the IRO review begins.



If your provider believes your situation is urgent under law (as defined above under Appeal for internal review), your external review will be conducted on an expedited basis. For expedited external reviews, you and Premera will be notified by phone, e-mail message or fax as soon as possible, but no later than 72 hours after receipt of your external review request. A written determination will follow.

The plan agrees that any statute of limitations (including the one-year contractual limitations period described below) or other defense based on timeliness is on hold during the time that the external review is pending. Your decision whether to file the external review will have no effect on your rights to any other benefits under the plan.

The external review process does not apply to appeals of denied claims for plan eligibility or for other appeals of denied claims that are not based on medical judgment.

Decision on the external review

The plan is bound by the IRO's decision. If the IRO overturned the final internal adverse determination, the plan will implement their decision. The IRO will notify you and Premera in writing of its determination on the external review no later than 45 days after receipt of your complete external review request.

Decisions upon the external review are the final decision under the plan's appeal process, and there are no further appeals available from Premera or Microsoft or any person administering claims or appeals under the

plan. However, you still have a right to file suit under ERISA Section 502(a) as a result of the external review decision.

Limits on your right to judicial review

You must follow the appeals process described above through the decision on the appeal before taking action in any other forum regarding a claim for benefits under the plan. Any legal action initiated under the plan must be brought no later than one year following the adverse determination on the appeal. This one-year limitations period on claims for benefits applies in any forum where you initiate legal action. If a legal action is not filed within this period, your benefit claim is deemed permanently waived and barred.



If you have questions about understanding a denial of a claim or your appeal rights, you may contact Premera Customer Service for assistance at (800) 676-1411. You may also seek assistance from the Employee Benefits Security Administration (EBSA) of the U.S. Department of Labor at (866) 444-EBSA (3272).

Right to recover benefits paid in error

If Premera makes a payment in error on your behalf to you or a provider, and you are not eligible for all or a part of that payment, Premera has the right to recover payment, including deducting the amount paid mistake from future benefits.

Note: Health care providers are not “beneficiaries” of the plan, and although Premera may make direct payment to health care providers for the convenience of participants and their dependents, such payments of services shall not be considered “benefits” available under the plan, or confer beneficiary standing upon a health care provider.

Notice of information use and disclosure

Premera may collect, use, or disclose certain information about you. This protected personal information (PPI) may include health information, or personal data such as your address, telephone number, or Social Security number. Premera may receive this information from, or release it to, health care providers, insurance companies, or other sources.

This information is collected, used, or released for conducting routine business operations such as:

- Underwriting and determining your eligibility for benefits and paying claims
- Coordinating benefits with other health care plans
- Conducting care management, case management, or quality reviews
- Fulfilling other legal obligations that are specified under the Group Contract



Case management is a service to help ensure that you receive appropriate and cost-effective medical care. Review the [glossary](#) for a full definition.

This information may also be collected, used, or released as required or permitted by law.

To safeguard your privacy, Premera takes care to ensure that your information remains confidential by having a company confidentiality policy and by requiring all employees to sign it.

If a disclosure of PPI is not related to a routine business function, Premera removes anything that could be used to easily identify you or we obtain your prior written authorization.

You have the right to request inspection and/or amendment of records retained by Premera that contain your PPI.



Please contact the Premera Customer Service department at (800) 676-1411 and ask a representative to mail a request form to you.

Section IV: Vision

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How the plan works

The vision plan helps pay for routine eye-care expenses when prescribed by a physician or optometrist. The vision coverage you have depends on the medical plan in which you participate, and may not pay the total cost of eye-care services and supplies.

All of the benefits for each vision plan are subject to the plan's exclusions and limitations. Each benefit may have additional eligibility criteria and exclusions and limitations. Specific coverage by medical plan is outlined on the following pages.

To be covered under the plans, vision services and supplies must be medically necessary and provided by a licensed vision provider practicing within the scope of his or her license.



You have a right to apply for continued vision coverage for you or your covered dependents if your coverage ends because you leave Microsoft or otherwise become ineligible. For more information, see the [Coverage if you leave Microsoft](#) section.

Where you can get care

Premera

If you are in a Premera Blue Cross (Premera) medical plan you may select any licensed eye doctor. However, if you go to an EyeMed provider you can get discounts on vision-related expenses that are not covered by the Microsoft vision plan. Premera members can also receive a discount on contact lenses through Vision Direct and laser vision correction procedures through TruVision providers.



- To locate an EyeMed provider call (866) 559-5252 or visit EyeMed's web site. To receive the EyeMed discount, tell the provider you are an EyeMed member in the Premera Blue Cross Extras! program, and provide your ID card and the discount code 9238502 at the time of your visit.
- To contact TruVision's partner, Vision Direct, about contact lenses, call (866) 831-8497 or visit the www.visiondirect.com. To receive the TruVision discount, use the code PREMERA10.
- To access a list of TruVision Laser Vision providers, contact TruVision at (877) 762-2020.

Group Health Cooperative (Washington only)

If you are in the Group Health Cooperative HMO Plan, you must obtain vision services and supplies from a Group Health Cooperative provider or facility. Group Health members can also receive refractive eye surgery through TruVision providers.



- To locate a Group Health vision provider or facility call (206) 901-4636 or (888) 901-4636 or visit Group Health Cooperative online.
- For a list of TruVision Laser Vision providers, contact TruVision at (877) 762-2020.

Kaiser Permanente (California only)

If you are in the Kaiser Permanente HMO Plan, you must obtain vision services and supplies from a Kaiser Permanente provider or facility.



To locate a Kaiser Permanente vision provider, call Member Services Contact Center at (800) 464-4000 or visit <http://www.kp.org>.

What the plan covers



Services and supplies must be medically necessary and are subject to all benefit exclusions and limitations and the plan's Exclusions and limitations.

Provider Visits

The coverage for provider visits depends on the medical plan in which you participate.

Premera	<p>One routine eye exam per year:</p> <ul style="list-style-type: none"> • In-network: 100% • Out-of-network: 100% of allowable charges <p>Other exams, as medically necessary:</p> <ul style="list-style-type: none"> • In-network: 90%, deductible applies • Out-of-network: 70% of allowable charges, deductible applies <p>To receive the EyeMed discount, tell the provider you are an EyeMed member in the Premera Blue Cross Extras! program, and provide your ID card and the discount code 9238502 at the time of your visit.</p>
Group Health Cooperative	<p>One routine eye exam per calendar year from a Group Health Cooperative provider or facility covered at 100%; other exams, including contact lens exams, and eye and contact lens exams for eye pathology, as medically necessary:</p> <ul style="list-style-type: none"> • \$20 copayment for primary care providers • \$40 copayment for specialists <p>Care from non-Group Health providers or facilities is not covered.</p>
Kaiser Permanente	<p>For information on coverage, view the evidence of coverage documents:</p> <ul style="list-style-type: none"> • Evidence of Coverage – Northern California • Evidence of Coverage – Southern California



An **allowable charge** is the negotiated amount that in-network providers contracted with your plan administrator (Premera, Group Health, or Kaiser Permanente). They have agreed to accept as payment in full for a covered service. Out-of-network providers may not accept the allowable charge as payment in full. You are responsible for paying the difference between the allowable charge and the amount your out-of-network provider charges.

A **copayment** is a fixed, up-front dollar amount that you're required to pay for certain covered services in the plan.

A **deductible** is the amount of covered medical costs you must pay each calendar year before the plan begins to pay its share of allowable charges. The deductible must be met before the plan begins paying a share of your vision costs.

In-network providers and facilities have contracted with your plan administrator (Premera, Group Health, or Kaiser Permanente) to provide services at a negotiated discount rate. Review the [glossary](#) for a full definition.

Out-of-network providers and facilities have not contracted with your plan administrator (Premera, Group Health, or Kaiser Permanente) to provide services at a negotiated discount rate. Review the [glossary](#) for a full definition.

Routine exams may include:

- Visual acuity testing
- Examination of the external parts of the eye, including the lids, conjunctiva, and sclera
- Pupillary reflexes or other testing for neurological integrity, as indicated
- Ophthalmoscopy (intraocular examination)
- Retinoscopy, where indicated
- Refraction at far and near points, as indicated
- Binocular testing at far and near points
- Case history, recommendations, and prescriptions

Hardware

The coverage for hardware depends on the medical plan in which you participate.



If you elect to use this refractive eye surgery benefit, you will no longer receive vision hardware coverage (such as glasses and contact lenses) for the full duration of your enrollment in a Microsoft vision plan. If you previously had refractive eye services from a non-TruVision provider, you are not eligible for this benefit.

Premera	<p>19 years and older: Glasses (including frames and lenses) and/or contacts including related examinations and fittings, are covered at 100% up to a maximum benefit of \$225 per member per calendar year.</p> <p>Under 19 years old: One pair of glasses (frames/lenses) or one pair of contacts (or one-year supply of disposable contacts) per calendar year and related fittings are covered at 100%.</p> <p>EyeMed providers can save you up to 45% on prescription eyeglasses. To locate an EyeMed provider, call (866) 559-5252 or visit EyeMed's web site. Use code 9238502 to receive the discount.</p> <p>The Vision Direct discount program offers a 10% discount off already-reduced contact lenses. Call (866) 831-8497 or visit www.visiondirect.com and use the code PREMERA10.</p>
Group Health Cooperative	Glasses (including frames and lenses) and/or contacts including related examinations and fittings, are covered at 100% up to a maximum benefit of \$225 per member per calendar

	<p>year. For children under 19 one pair of glasses (frames/lenses) or one pair of contacts (or one year of disposable contacts) per calendar year.</p> <p>Contact lenses for eye pathology are covered at 100%. One contact lens per diseased eye in lieu of an intraocular lens is covered following cataract surgery provided the member has been continuously covered by Group Health since such surgery. In the event a member's age or medical condition prevents the member from having an intraocular lens or contact lens, framed lenses are available. Replacement of lenses for eye pathology, including following cataract surgery, is covered only once within a 12-month period and only when needed due to a change in the Member's prescription.</p> <p>You must obtain vision supplies from a Group Health Cooperative provider or facility. Supplies from non-Group Health providers or facilities are not covered. To locate a Group Health vision provider, call (206) 901-4636 or (888) 901-4636 or visit Group Health Cooperative online at http://www.gheyecare.org/.</p>
Kaiser Permanente	<p>For information on coverage, view the evidence of coverage documents:</p> <ul style="list-style-type: none"> • Evidence of Coverage – Northern California • Evidence of Coverage – Southern California

The following criteria apply for vision hardware coverage:

- They must be prescribed and furnished by a licensed or certified vision care provider
- They must be listed as covered by this benefit
- They must not be excluded from coverage under this plan
- Benefits for hardware are provided in the calendar year when the hardware is paid for, as reflected on the invoice from the provider
- Prescription sunglasses, prescription safety glasses, and special features, such as tinting or coating, may also be covered
- Vision hardware benefits are based on the maximum benefit for services and supplies. Charges that exceed what is covered under this benefit are not covered under this plan.

Eye Surgery

The Premiera and Group Health Cooperative vision plans cover refractive eye surgery with TruVision providers as described in the table below.



If you elect to use this refractive eye surgery benefit, you will no longer receive vision hardware coverage (such as glasses and contact lenses) for the full duration of your enrollment in a Microsoft vision plan. If you previously had refractive eye services from a non-TruVision provider, you are not eligible for this benefit.

Premiera	Covers 100% of allowable charges, up to the lifetime benefit maximum benefit of \$500 per participant when performed by TruVision Laser Vision Surgery in-network providers. For the list of TruVision providers, contact TruVision at (877) 762-2020.
Group Health Cooperative	Covers 100%, up to the lifetime benefit maximum benefit of \$500 per participant when performed by TruVision Laser Vision Surgery in-network providers. For the list of TruVision providers, contact TruVision at (877) 762-2020.
Kaiser Permanente	Laser vision surgery is not covered.



A **lifetime benefit maximum** is the most a plan will pay toward a benefit for a member. Review the [glossary](#) for a full definition.

Covered services include but are not limited to:

- Pre- and post-operative exams
- LASIK (LASIK, Custom LASIK, Bladeless LASIK)
- Photorefractive Keratectomy (PRK)
- Re-treatments for two years following initial treatment (incurred after January 1, 2007) from a TruVision provider



Other medically necessary eye surgery may be covered by your medical plan:

- [Health Savings Plan](#)
- [Group Health Cooperative HMO](#)
- [Kaiser Permanente HMO](#)
- [Hawaii Only Plan](#)

Exclusions and limitations

Premera

Exclusions

The following are not covered:

- Artificial eyes (covered under the medical plan as prostheses)
- Nonprescription eyeglasses (for example, sunglasses or safety glasses) or contact lenses, or other special-purpose vision aids (such as magnifying attachments)
- Industrial vision equipment
- Sports-related vision equipment (such as scuba or ski goggles) even if prescribed
- Services or supplies required by an employer as a condition of employment
- Services or supplies received from a medical department maintained by an employer, a mutual benefit association, labor union, trustee, or similar type group
- Any additional charges for the repair of glasses or contact lenses, or service charges to cover potential breakage or damage to eyewear
- Supplies used for the maintenance of contact lenses
- Services and supplies (including hardware) received after your coverage under this benefit has ended, except when all of the following requirements are met:
 - You ordered covered contact lenses, eyeglass lenses, and/or frames before the date your coverage under this benefit or plan ended
 - You received the contact lenses, eyeglass lenses, and/or frames within 30 days of the date your coverage under this benefit or plan ended
 - Vision therapy (covered for approved conditions under the medical plan)
 - Prepaid vision policies

- Eyeglasses that can be purchased without a prescription are not covered (for example "readers" regardless if prescribed)
- If you elect to use the refractive eye surgery benefit, you will no longer receive vision hardware coverage (such as glasses and contact lenses) for the full duration of your enrollment in a Microsoft vision plan
- Refractive eye surgery with a non TruVision provider

Limitations

Payment will not be made for more than one complete, routine, eye examination in any calendar year. Payment will also not be made for services or supplies received primarily for cosmetic purposes, other than for the selection of prescription contact lenses in place of eyeglasses.

Group Health Cooperative

Exclusions

Vision benefits do not provide the following:

- Industrial and sports-related vision equipment, even if prescribed
- Evaluations and surgical procedures to correct refractions not related to eye pathology and complications related to such procedures
- Sunglasses and safety frames and lenses
- Non-prescription lenses
- Services or supplies required as a condition of employment
- Any additional charges for the repair of glasses or contact lenses or service charges to cover potential breakage or damage to eyewear
- Orthoptic therapy. (i.e., eye training)

Kaiser Permanente

For information on exclusions and limitations, view the evidence of coverage documents:

- [Evidence of Coverage – Northern California](#)
- [Evidence of Coverage – Southern California](#)

How to file a claim

Premera

In most cases, when you receive care from an in-network provider, your provider will submit bills directly to Premera, and this submission is your claim for benefits.

If your provider does not submit a bill directly to Premera or you receive refractive eye surgery services through TruVision, you will need to pay for the services and [submit a claim](#) to Premera for reimbursement.



For more information about filing a claim, review the How to file a claim section under your medical plan:

- [Health Savings Plan](#)
- [Hawaii Only Plan](#)

Group Health Cooperative

For all covered vision care except refractive eye surgery, Group Health Cooperative providers will bill the plan directly so there is no need to file a claim.

For refractive eye surgery services through TruVision, you must pay for the services and submit a Group Health Claim form to Group Health for reimbursement.



For more information about filing a claim, review the [How to file a claim](#) section for the Group Health Cooperative HMO plan.

Kaiser Permanente

For information on how to file a claim, view the evidence of coverage documents:

- [Evidence of Coverage – Northern California](#)
- [Evidence of Coverage – Southern California](#)

Section V: Dental

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How the plan works

You have two dental options from which to select: a standard level of coverage in the Dental Basic Plan or a higher level of coverage, including orthodontia, through the Dental Plus Plan. Both plans allow you to seek services from in-network or out-of-network providers. In-network preventive care is covered at 100% and Out-of-Network preventive care is covered at 100% of allowable charges. For all other care, you must pay an annual deductible before the plan pays a share of the cost.

All of the dental benefits are subject to the plan's exclusions and limitations. Each benefit may have additional eligibility criteria and exclusions and limitations. Specific coverage is outlined on the following pages.

To be covered under the plans, dental services and supplies must be dentally necessary and provided by a licensed dental provider practicing within the scope of his or her license. Services may also be provided by a dental hygienist under the supervision of and billed by a licensed dentist.



A **dentally necessary service or supply** meets certain criteria including:

- It is essential to the diagnosis or the treatment of an illness, accidental injury, or condition that is harmful or threatening to the patient's life or health, unless it is provided for preventive services when specified as covered under the plan
- It is appropriate for the dental condition as specified in accordance with authoritative dental or scientific literature and generally accepted standards of dental practice

Review the [glossary](#) for a full definition.



You have a right to apply for continued dental coverage for you or your covered dependents if your coverage ends because you leave Microsoft or otherwise become ineligible. For more information, see the [Coverage if you leave Microsoft](#) section.

Where you can get care

You may seek dental care from any licensed dental provider and still have coverage. However, you will receive the lower, negotiated rates and the highest coverage levels by staying within the Premera network. Please review the [What you pay](#) section for information on coverage levels.



To locate in-network providers in your area, use [Premera's Provider Directory](#) or call Premera Blue Cross at (800) 676-1411.

Hospital and physician services

Dental care is covered when provided by a hospital or a physician only if the following two conditions are met:

- When adequate dental treatment cannot be rendered without the use of the hospital
- A health problem makes it medically necessary to perform the dental work at the hospital

Any charges for the hospital facility or ambulatory surgical center facility and anesthesia charges will be considered under the benefits of your medical plan.

Prior Authorization

Prior authorization, also referred to as a pre-service review, is recommended to determine coverage is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.



Prior authorization is an advance determination by Premera that the service is medically necessary and that the member's plan has benefits available for the service being requested. This determination is offered in certain situations where medical records must be provided to establish medical necessity before the plan will pay for the service. Services are subject to eligibility and benefits at the time of service.

Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition based on national, evidence-based guidelines. Premera and Microsoft reserve the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.

What you pay

You pay nothing for diagnostic and preventive services (Class I), when you use in-network providers.



For a full list of covered services, call Premera customer service at (800) 676-1411.

For other care, you pay 100% of your eligible expenses until you spend up to the amount of the deductible, which is \$25 for individual coverage and \$75 for family coverage. If you reach the deductible, then you begin to pay a percentage of the allowable charges, called coinsurance, and the plan pays the rest. The amount paid by the plan depends on the type of care you seek and the plan you choose.

Benefit coverage after you pay deductible (\$25 individual / \$75 family)		
	Dental Plus	Dental Basic
Class I – Diagnostic and preventive services For a full list of covered services, call Premera customer service at (800) 676-1411.	Plan pays 100% of allowable charges	Plan pays 100% of allowable charges
Class II – Basic services Basic restorative services, endodontics, periodontics, and oral surgery	Plan pays 85% of allowable charges, after deductible	Plan pays 50% of allowable charges, after deductible
Class III – Major services Major restorative services, installation of bridges, and dentures	Plan pays 50% of allowable charges, after deductible	Plan pays 50% of allowable charges, after deductible
Orthodontia benefits One-time \$50 deductible per member; \$2,000 lifetime benefit maximum benefit per member	Plan pays 50% of allowable charges, after deductible	Not covered

If you use in-network providers, you'll receive the lower Premera-negotiated rate, called the allowable charge. If you use out-of-network providers, only the Premera allowable charge is applied to your

deductible. You are responsible for the provider charge over the allowable charge. Examples of how the plan pays for in- and out-of-network care follow below.

The plan pays up to a maximum amount of 2,000 for Dental Plus and \$1,500 for Dental Basic per member each calendar year. After the plan pays this annual limit, you are responsible for 100% of the cost when you seek care. The Dental Plus plan also includes a \$2,000 lifetime benefit maximum per member for the orthodontia benefit.

Services received in excess of the annual maximums are not covered by this benefit. Any network discounts for in network providers do not apply to services received in excess of the benefit limit.



An **allowable charge** is the negotiated amount that Premera in-network providers have agreed to accept as payment in full for a covered service. Out-of-network providers may not accept the allowable charge as payment in full. You are responsible for paying the difference between the allowable charge and the amount your out-of-network provider charges. Only the allowable charge will be applied to your deductible.

A **deductible** is the amount of covered dental costs you must pay each calendar year before the plan begins to pay its share of allowable charges.

In-network providers and facilities have contracted with your plan administrator to provide services at a negotiated discount rate. Review the [glossary](#) for a full definition.

Out-of-network providers and facilities have not contracted with your plan administrator to provide services at a negotiated discount rate. Review the [glossary](#) for a full definition.

A **lifetime benefit maximum** is the most a plan will pay toward a benefit for a member. Review the [glossary](#) for a full definition.

Example

Pradip needs a crown, which is a Class III service. He can choose an in-network or an out-of-network provider. Both charge \$975, but the in-network provider accepts the lower Premera-negotiated rate of \$700.

Pradip has employee-only coverage in the Dental Plus plan and hasn't met his deductible yet. He chooses an in-network provider and pays:

- The \$25 deductible
- 50% of the remaining charge ($\$675 \times 50\% = \337.50)

If Pradip had chosen an out-of-network provider, he would have paid \$275 more (the difference between the out-of-network provider's bill and the allowable charge ($\$975 - \$700 = \$275$)).

Example

Mary's daughter Judith needs a nightguard. The charge is \$490, but the in-network allowable charge rate is \$300.

Mary has family coverage in the Dental Plus Plan and takes her daughter to an out-of-network provider. She pays:

- The \$25 deductible
- 15% of the remaining allowable charge ($\$275 \times 15\% = \41.25)
- The difference between the out-of-network provider's bill and the allowable charge ($\$490 - \$300 = \$190$)
- Mary's cost for the visit is \$231.25

If Mary had chosen an in-network provider, she would have saved \$190.

Dental pre-determination

When charges for a proposed dental service or a series of dental services are expected to exceed \$350, your dentist should submit the recommended course of treatment and fees to Premera for a pre-

determination of what will be paid for the services. This dental pre-determination is only an estimate and not a guarantee of payment.

When the treatment plan is finished, the dentist should resubmit a claim for payment. Premera will pay benefits based on your continued eligibility and remaining balance of your annual maximum.

If this dental pre-determination process is not followed, payment will be determined by Premera, taking into account alternate procedures or services, based on acceptable standards of dental practice.

Emergency treatments, oral examinations, and dental X-rays, are considered part of a course of treatment, but these services may be provided before the dental pre-determination is made.

What the plan covers

This section provides details on the major benefits of the dental plan, including coinsurance coverage for in-network and out-of-network care in three categories:

- [Class I services – Diagnostic and preventive services](#)
- [Class II services – Basic restorative, endodontics, periodontics, and oral surgery](#)
- [Class III services – Major restorative services and installation of bridges and dentures](#)



Services and supplies must be dentally necessary and are subject to all benefit exclusions and limitations and the plan's [Exclusions and limitations](#).



Prescription drugs prescribed by your dentist are covered under your medical plan.

- [Health Savings Plan](#)
- [Kaiser Permanente HMO](#)
- [Group Health Cooperative HMO](#)
- [Hawaii Only Plan](#)

Class I services—Diagnostic and preventive services

Dental cleaning (Prophylaxis)

In-network: 100%

Out-of-network: 100% of allowable charges

Two prophylaxes are covered in each calendar year. Services include cleaning, removal of plaque, calculus, and stains from the tooth surface (excluding bleaching or whitening).

Dental X-rays

In-network: 100%

Out-of-network: 100% of allowable charges

Covered dental X-rays include:

- Either a full mouth X-ray or panoramic X-ray or Cone Beam Film, once in a 36-month period, except as covered under the [orthodontia](#) benefit
- Bitewing X-rays

- Periapical X-rays
- Occlusal X-rays

The frequency of full mouth X-rays or panoramic X-ray or cone beam file may be allowed when it is for the diagnosis of a specific condition requiring treatment.

Emergency treatment for dental pain relief

In-network: 100%

Out-of-network: 100% of allowable charges

Emergency treatment for dental pain relief, palliative treatment, is covered. Chart notes, office records, and/or a description of the services provided are required from your provider.

Full mouth debridement

In-network: 100%

Out-of-network: 100% of allowable charges

Full mouth debridement (the removal of plaque and tartar that have accumulated on the teeth) to enable a comprehensive evaluation and diagnosis is covered once every three calendar years.

Oral evaluation

In-network: 100%

Out-of-network: 100% of allowable charges

Two preventive oral evaluations, or "checkups," are covered in each calendar year.

Emergency oral evaluations are covered when a member is in pain or needs immediate care due to a dental emergency, trauma, or acute infections. Emergency oral evaluations will not count toward the preventive oral evaluation limit of two per calendar year.

Oral pathology laboratory

In-network: 100%

Out-of-network: 100% of allowable charges

Oral pathology laboratory procedures are covered. Coverage for the removal of the tissue samples is under the [Class II Services](#) benefit.

Periodontal maintenance

In-network: 100%

Out-of-network: 100% of allowable charges

Periodontal maintenance (a deeper cleaning that may include site-specific scaling and root planning where indicated) is a covered service.

Prescription Drugs

Dental Plus

- *In Network: 100%**
- *Out of Network: 100%**

Dental Basic

- *In Network: 100%**
- *Out of Network: 100%**

The Plan covers prescription medications and drugs, when dispensed by your dentist for in office use.

*If you receive a written prescription from your dentist and have it filled at a retail pharmacy, your prescription benefits under your medical plan will apply. Refer to your medical plan for additional information regarding prescription drugs filled at a retail pharmacy.

If you are a member of the HMO Plan (Group Health Cooperative or Kaiser Permanente), the pharmacy will not fill prescriptions written by a dentist. However, medications and drugs prescribed by your dentist can be filled at your local pharmacy and you can obtain reimbursement by completing and submitting the Premera Claim Form.

Preventive resin restoration

In-network: 100%

Out-of-network: 100% of allowable charges

Preventive resin restorations are covered on permanent teeth.

Professional consultation

In-network: 100%

Out-of-network: 100% of allowable charges

Professional consultations by dental specialists, such as endodontists and periodontists, are covered when requested by the dentist. Consultations by a dental specialist, will not count toward the preventive dental evaluation limit of two per calendar year.

A professional consultation performed by an orthodontist is not covered under Class I Benefits.

Sealants

In-network: 100%

Out-of-network: 100% of allowable charges

This benefit covers sealants for permanent and primary teeth.

Space maintainers

In-network: 100%

Out-of-network: 100% of allowable charges

Space maintainers are covered when designed to preserve the space between teeth caused by the premature loss of a primary tooth (also called a baby tooth). This benefit is available for members only under the age of 17.

Topical fluoride or fluoride varnish

In-network: 100%

Out-of-network: 100% of allowable charges

Topical fluoride or fluoride varnish treatment is covered twice in each calendar year.

Class II services—Basic restorative, endodontics, periodontics, and oral surgery

Anesthesia provided in a dental provider's office

Dental Plus

- *In-network: 85%, deductible applies*
- *Out-of-network: 85% of allowable charges, deductible applies*

Dental Basic

- *In-network: 50%, deductible applies*
- *Out-of-network: 50% of allowable charges, deductible applies*

General anesthesia, intravenous conscious sedation/analgesia, and nitrous oxide provided in a dental provider's office are covered when administered in connection with a covered [Class II](#) or [Class III](#) dental service.

Crown, bridge and denture repair

Dental Plus

- *In-network: 85%, deductible applies*
- *Out-of-network: 85% of allowable charges, deductible applies*

Dental Basic

- *In-network: 50%, deductible applies*
- *Out-of-network: 50% of allowable charges, deductible applies*

This benefit covers repairs to crowns, bridges, and full and partial dentures when services are performed at least six months after the initial placement.

Crown posts and core build-up

Dental Plus

- *In-network: 85%, deductible applies*
- *Out-of-network: 85% of allowable charges, deductible applies*

Dental Basic

- *In-network: 50%, deductible applies*
- *Out-of-network: 50% of allowable charges, deductible applies*

Crown posts and core build-ups are covered.

Endodontic treatment

Dental Plus

- *In-network: 85%, deductible applies*
- *Out-of-network: 85% of allowable charges, deductible applies*

Dental Basic

- *In-network: 50%, deductible applies*
- *Out-of-network: 50% of allowable charges, deductible applies*

Covered services for the treatment of diseases of the tooth pulp and root canal include the following:

- Pulpotomy and endodontic (root canal) therapy
- Direct Pulp Cap
- Endodontic retreatment
- Apexification/recalcification and apicoectomy/periradicular surgery
- Retrograde filling

Fillings (restorations)

Dental Plus

- *In-network: 85%, deductible applies*
- *Out-of-network: 85% of allowable charges, deductible applies*

Dental Basic

- *In-network: 50%, deductible applies*
- *Out-of-network: 50% of allowable charges, deductible applies*

Fillings using amalgam and resin-based composite filling materials are covered to restore decayed, cracked, broken, or fractured teeth.

Nightguards

Dental Plus

- *In-network: 85%, deductible applies*
- *Out-of-network: 85% of allowable charges, deductible applies*

Dental Basic

- *In-network: 50%, deductible applies*
- *Out-of-network: 50% of allowable charges, deductible applies*

Nightguards are covered for treatment of bruxism and other occlusal factors. Adjustments to nightguards are covered in lieu of replacement.

Occlusal adjustments

Dental Plus

- In-network: 85%, deductible applies
- Out-of-network: 85% of allowable charges, deductible applies

Dental Basic

- In-network: 50%, deductible applies
- Out-of-network: 50% of allowable charges, deductible applies

Limited and full occlusal adjustments are covered when not part of a primary procedure.

Oral surgery

Dental Plus

- *In-network: 85%, deductible applies*
- *Out-of-network: 85% of allowable charges, deductible applies*

Dental Basic

- *In-network: 50%, deductible applies*
- *Out-of-network: 50% of allowable charges, deductible applies*

Coverage includes customary postoperative treatment furnished in connection with oral surgery, as follows:

- Surgical extraction of one or more teeth
- Surgical removal of erupted or impacted teeth
- Surgical removal of residual tooth roots
- Bone Replacement graft for ridge augmentation, ridge preservation or repair of bony defect
- Alveolectomy, vestibuloplasty, and frenectomy
- Reimplantation of natural tooth or transplantation of a natural tooth
- Incision and drainage of an abscess related to the tooth structure or gingival tissue
- Excision or removal of a tumor or cyst related to the tooth structure or gingival tissue
- Biopsy of soft or hard tissue related to the tooth structure or gingival tissue

Periodontal scaling and root planing

Dental Plus

- *In-network: 85%, deductible applies*
- *Out-of-network: 85% of allowable charges, deductible applies*

Dental Basic

- *In-network: 50%, deductible applies*
- *Out-of-network: 50% of allowable charges, deductible applies*

Scaling and root planing are covered, but not more often than once per quadrant of the mouth twice per calendar year.

Periodontal surgery

Dental Plus

- *In-network: 85%, deductible applies*
- *Out-of-network: 85% of allowable charges, deductible applies*

Dental Basic

- *In-network: 50%, deductible applies*
- *Out-of-network: 50% of allowable charges, deductible applies*

Covered periodontal surgical services include the following services:

- Osseous surgery that includes gingivectomy, gingivoplasty, and gingival flap procedures
- Clinical crown lengthening
- Guided tissue regeneration
- Bone replacement and tissue grafts
- Biological materials to aid in tissue regeneration (approved and indicated for use by the FDA)
- Localized delivery of antimicrobial agents

Pin retention for fillings

Dental Plus

- *In-network: 85%, deductible applies*
- *Out-of-network: 85% of allowable charges, deductible applies*

Dental Basic

- *In-network: 50%, deductible applies*
- *Out-of-network: 50% of allowable charges, deductible applies*

Pin retention services for fillings are covered.

Re-cementing bridges, inlays, onlays, and crowns

Dental Plus

- *In-network: 85%, deductible applies*
- *Out-of-network: 85% of allowable charges, deductible applies*

Dental Basic

- *In-network: 50%, deductible applies*
- *Out-of-network: 50% of allowable charges, deductible applies*

The re-cementing of bridges, inlays, onlays, and crowns is covered.

Simple extractions (one or more teeth)

Dental Plus

- *In-network: 85%, deductible applies*
- *Out-of-network: 85% of allowable charges, deductible applies*

Dental Basic

- *In-network: 50%, deductible applies*
- *Out-of-network: 50% of allowable charges, deductible applies*

Simple extraction of one or more teeth is covered.

Study models

Dental Plus

- *In-network: 85%, deductible applies*
- *Out-of-network: 85% of allowable charges, deductible applies*

Dental Basic

- *In-network: 50%, deductible applies*
- *Out-of-network: 50% of allowable charges, deductible applies*

Study models are covered no more often than once in any 36-month period.

Study models performed in conjunction with orthodontia are paid under the [orthodontia](#) benefit.

Therapeutic parenteral medication

Dental Plus

- *In-network: 85%, deductible applies*
- *Out-of-network: 85% of allowable charges, deductible applies*

Dental Basic

- *In-network: 50%, deductible applies*
- *Out-of-network: 50% of allowable charges, deductible applies*

The single or multiple administrations within the dental office by the treating dentist of antibiotics, steroids, and anti-inflammatory drugs and other therapeutic medications are covered.

Class III services—Major restorative services and installation of bridges and dentures

Prosthetic services and supplies

Dental Plus

- *In-network: 50%, deductible applies*
- *Out-of-network: 50% of allowable charges, deductible applies*

Dental Basic

- *In-network: 50%, deductible applies*
- *Out-of-network: 50% of allowable charges, deductible applies*

The plan covers the following prosthetic services and supplies:

- Initial gold, porcelain, or ceramic inlays, onlays, crowns, and veneers, but only when the tooth, as a result of extensive cavities or fracture, cannot be restored with an amalgam or composite filling material. Charges for crowns for the purpose of periodontal splinting are not covered.
- Initial placement of full or partial dentures and fixed bridgework
- Replacement of full or partial dentures, inlays, onlays, veneers, crowns, or fixed bridgework that cannot be made serviceable
- Addition of one or more teeth to an existing partial denture
- Relining, rebasing and adjustments of existing dentures, but only if it has been at least one year since the denture was placed, and not more often than once in any two-year period
- Dental implants and implant-related services

Orthodontia (Dental Plus only)

Dental Plus

- *In-network: 50%, deductible applies, \$50 orthodontia deductible applies, up to \$2,000 lifetime benefit maximum*
- *Out-of-network: 50% of allowable charges, deductible applies, \$50 orthodontia deductible applies, up to \$2,000 lifetime benefit maximum*

The dental deductible does not apply to this benefit. However, you must satisfy a separate, one-time \$50 deductible before this benefit is provided. **There is a \$2,000 combined lifetime benefit maximum for both in-network and out-of-network.**

Covered dental charges include services and supplies provided by a licensed dentist or orthodontist in connection with orthodontic treatment (other than for extractions) to correct malposed teeth. The plan covers only services provided while the member has Dental Plus coverage.

If treatment started before joining this plan, the \$2,000 lifetime benefit maximum benefit for orthodontia treatment is limited to continuing monthly adjustments, retention, or any new phase of orthodontia treatment performed while coverage is in effect under this plan.

Orthodontia services may be eligible for payment under the medical plan for dependents born with cleft/lip palate or other severe craniofacial anomalies. To qualify for benefits, the condition must meet medically necessary criteria in Premera's medical policy. Prior authorization is recommended for members to determine medical benefit eligibility for this service.

Prior Authorization

Prior authorization, also referred to as a pre-service review, is recommended to determine coverage is available before the service occurs. Either the member or the provider may contact Premera for prior authorization.



Prior authorization is an advance determination by Premera that the service is medically necessary and that the member's plan has benefits available for the service being requested. This determination is offered in certain situations where medical records must be provided to establish medical necessity before the plan will pay for the service. Services are subject to eligibility and benefits at the time of service.

Prior authorization confirms that the treatment plan submitted by the treating provider is medically necessary for the condition based on national, evidence-based guidelines. Premera and Microsoft reserve the right to have appropriate medical professionals review current treatment at any time to determine if medical necessity criteria continue to be met.



Contact Premera at (800) 676-1411 for a copy of Premera's medical policy addressing orthodontia for repair of cleft palate and other severe congenital anomalies.

Dental coverage extended

Dental coverage will be extended for covered services that are ordered before your coverage ends if the covered service is delivered or completed within 30 days. This includes:

- Dentures
- Fixed bridgework
- Crown
- Root canal therapy



To be **considered an "ordered service" the following must have been done:**

1. Impressions used to form the dentures, crowns, or fixed bridgework have been taken
2. The teeth have been fully prepared for fixed bridgework and crowns

This is also described in the [When benefits coverage ends](#) section.

Exclusions and limitations

Dental exclusions and limitations include:

- Services that are not listed in this dental plan overview as covered or that are directly related to any condition, service, or supply that is not covered under this Dental plan

- Dental services received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trustee, or similar person or group
- Occupational accidents
- Appliances or restorations necessary to increase vertical dimensions
- Any charges covered by a medical plan
- Orthodontic services or dental services (such as X-rays) required as a result of orthodontia, except as stated under the Dental Plus orthodontia benefit (orthodontic services and related care are not covered under the Dental Basic)
- Services performed for cosmetic reasons including but not limited to enamel microabrasion, odontoplasty, internal or external bleaching, dental veneers and crown lengthening
- Charges to the extent they are billed amounts above the allowable charges
- Any service or supplies for which no charge is made, or for which a charge is made because this plan is in effect, or for services or supplies for which the member is legally liable because this plan is in effect
- Services or supplies considered part of the primary procedure
- Services or supplies prescribed by a member to himself or herself or by a provider who is in any way related to the member. This also includes covered dependents under the plan who are living within the member's household.
- Oral hygiene instruction
- Nutritional or tobacco counseling for the control of and prevention of dental or oral disease, caries, and conditions
- Behavior management
- Services or supplies for which a claim was not made to Premiera Blue Cross within 12 months of the date of service. Corrected claims and COB claims need to be submitted within 12 months from the original claim submission date.
- Charges resulting from changing from one dentist to another while receiving treatment or from receiving care from more than one dentist for one dental procedure, to the extent that the total charges billed exceed the amount that would have been billed if one dentist had performed all the required dental services
- Services or supplies for or related to orthognathic surgery, temporomandibular joint dysfunction (TMJ), myofacial pain dysfunction (MPD), or similar conditions of the jaw joint
- Services that are incomplete, temporary, interim or provisional (other than provisional splints)
- Expenses in excess of the applicable benefit maximums
- Benefits that overlap or duplicate benefits for which the member is eligible under any other group benefit plan, workers' compensation or similar employee benefit law, Medicare A or B, or government-sponsored program of any type. Also not covered are expenses that are in any way reimbursable through "no fault" automobile insurance.
- Charges for or in connection with services or supplies that are determined to be experimental or investigational or not generally accepted as a standard of good dental practice
- Extra or replacement items such as extra dentures or other appliances, including replacements due to loss or theft
- Hospital facility or ambulatory surgical center facility fees, benefits may be available under the Medical Plan
- Home visits, or home-use products such as take-home fluoride, toothbrushes, floss and toothpaste

- Testing and Treatment Services such as genetic or caries susceptibility tests or testing and treatment for mercury sensitivity or that are allergy-related
- Services or supplies that are not dentally necessary for diagnosis, care or treatment of a disease, illness, or injury
- Precision attachments and personalization of appliances
- When payment is subject to the plan's Coordination of Benefits (COB) provisions, and you fail to follow the rules of the primary plan, this plan would pay nothing for that expense
- Replacement of lost or stolen prosthesis originally paid for by the plan Prescription, materials, or supplies that are not approved or indicated for use by the FDA
- Fabrication of athletic mouth guards
- Dental treatment simulations utilizing digital or 3-D imaging
- Indirect pulp caps

How to file a claim

In most cases, when you receive care from an in-network provider, your provider will submit bills directly to Premera, and this submission is your claim for benefits. If your provider does not submit a bill directly to Premera, you will need to submit a claim for benefits.

If possible, you should submit the claim form within 30 days of the service. The plan will not reimburse claims submitted more than 12 months after the date of service.

To submit a claim:

1. Download the [Premera claim form](#) or e-mail Premera at microsoft@premera.com to request a claim form.
2. Complete the claim form, including all of the following information:
 - a. Your name and the member's name
 - b. Identification numbers shown on your identification card (including the alpha 3-digit, or MSJ)
 - c. Provider's name, address, and tax identification number
 - d. If you are seeking secondary coverage from the Microsoft health plan, information about other insurance coverage related to the claim at hand, including a copy of their Explanation of Benefits (EOB), if applicable
 - e. If treatment is as a result of an accident: the date, time, location and brief description of the accident
 - f. Date of onset of the illness or injury
 - g. Date of service
 - h. Diagnosis or ICD-10 code (this information can be found on the provider's bill)
 - i. Procedure codes (CPT-4, HCPCS, ADA, or UB-92) or descriptive English language for each service (this information can be found on the provider's bill)
 - j. Itemized charges for each service rendered by provider
3. Sign the form in the space provided and attach the itemized provider's bill
4. Mail the completed form to:

Premera Blue Cross
 P.O. Box 91059
 Seattle, WA 98111-9159
 Fax (800) 676-1477



COBRA-eligibility claims should be submitted as described in the [Continuation of coverage for health benefits](#) section.

In the following circumstances, you may submit claims according to the [appeals process](#):

- If you cannot submit the claim in a timely manner due to circumstances beyond your control
- If your claim regards plan eligibility for you, your spouse/domestic partner, or dependent child

Claim review and payment

Premera will send you an Explanation of Benefits (EOB) or other communication notifying you of their decision on your claim no more than 30 days after Premera receives the claim. Premera may extend this 30-day period for up to 15 days if the extension is required due to matters beyond the control of Premera.



Explanation of benefits (EOB) is the statement you receive from Premera Blue Cross detailing how much the provider billed, how much (if any) the plan paid, and the amount that you owe the provider (if any).

You will have at least 45 days to provide any additional information requested of you by Premera, if an extension is required due to Premera needing additional information from you or your health care providers.

Premera will make a payment to the employee, a dependent (age 13 or older), a provider, or another carrier. Payments are subject to applicable law and regulation:

- Premera may make payments on behalf of an enrolled child to a non-enrolled parent or state agency to which the plan is required by applicable law to direct such payments
- Payments made will discharge the plan to the extent of the amount paid, so that the plan is not liable to anyone due to its choice of payee

Denied claims notice

If all or part of your claim is denied, Premera will send you an Explanation of Benefits (EOB) or other notice with the following information:

- The specific reason or reasons for the denial
- Reference to the specific plan provisions on which the denial is based
- A description of any additional material or information needed from you and the reason it is needed
- An explanation of the appeals procedures and the applicable time limits
- A statement regarding any internal rule, guideline, protocol or other criterion that was relied upon in making the adverse determination (a copy of which will be provided free upon request)
- If the denial is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment that led to this determination (a copy of which will be provided free upon request)
- If the claim is an urgent care claim (as defined under law), a description of the expedited review process applicable to such claims
- If you have filed a claim with Premera relating to plan eligibility, and this claim is denied, Premera will send you a notice explaining your appeal rights
- Notice regarding your right to bring legal action following a denial on appeal

For medical and transplant benefits, the denial will also include:

- Information sufficient to identify the claim involved, including the date of service, health care provider and claim amount, if applicable
- The denial code and its meaning
- A description of the plan's standard for denying the claim
- Information regarding available internal and external appeals, including how to initiate an appeal
- Contact information for Premera Customer Service or the Employee Benefits Security Administration (EBSA) of the U.S. Department of Labor to assist participants with the internal and external appeals process

Appeal for internal review

If the plan denies your claim, you may appeal for an internal review of the decision within 180 days of receiving the Explanation of Benefits (EOB).



An **appeal** is a written request to reconsider a written or official verbal adverse determination to deny, modify, reduce or end payment, coverage or authorization of health care coverage or eligibility to participate in the plan. This includes admissions to and continued stays in a facility. The process also applies to Flexible Spending Account appeals for reimbursement but does not apply to appeals of denied COBRA eligibility claims.



If you fail to file the internal appeal within 180 days of receiving the Explanation of Benefits, you will permanently lose your right to appeal the denied claim.

Submitting an appeal for internal review

You must provide the following information as part of your written appeal to the Premera Appeals Department.

- Your name
- Your Premera member number
- The name of this plan, and
- A concise statement of why you disagree with the decision, including facts or theories supporting your claim

Your written request may (but is not required to) include issues, comments, documents, and other records you want considered in the review.



The appeal should be submitted to Premera at the following address:

Appeals Coordinator
Premera Blue Cross
P.O. Box 91102
Seattle, WA 98111-9202

You may, at your own expense, have a representative act on your behalf. If you want to appoint someone to act for you in the appeals process (including your provider), you must submit a completed and signed [Premera Internal Appeals Authorization form](#) with your written appeal for internal review to the appeals coordinator at the address above.

In the case of an urgent care appeal you may submit your appeal request in writing and all necessary information may be transmitted between you and the plan by facsimile. If your provider believes your situation is urgent as defined under law and so notifies Premera, your appeal will be conducted on an expedited basis. Notification will be furnished to you as soon as possible, but not later than 72 hours after receipt of the expedited appeal. Your appeal should clearly indicate your request for an expedited appeal.

You may begin an external independent review at the same time as Premera Blue Cross's internal review process if this is an urgent situation or you are in an ongoing course of treatment. The external review agency is not legally affiliated or controlled by Premera. The external review agency decision is final and is generally binding upon the Plan.



To file an urgent care appeal request, you may fax a request to (425) 918-5592.



An urgent situation means one in which your provider concludes that the application of the standard time periods for making determinations could seriously jeopardize your life or health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

The new definition of urgent is as follows:

If your provider believes the situation meets the definition of urgent under the law and we agree, your review will be conducted on an expedited basis. If you are currently in the hospital, you have the right to an expedited appeal and we will review your case and provide you with a decision within 24-72 hours.

We will not expedite your appeal if you have already received the services you are appealing, or if you do not meet the above requirements.

Internal review and timeframe

All the information you submit will be taken into account on appeal, even if it was not reviewed as part of the initial decision. You may ask to examine or receive free copies of all pertinent plan documents, records, and other information relevant to your claim by requesting these from Premera. If the adverse benefit determination involved dental judgment, the review will be provided by a dental care provider.

In the event any new or additional information (evidence) is considered, relied on or generated by Premera in connection with your appeal, Premera will provide this information to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Premera, Premera will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that that you will have an opportunity to respond.

If you have not had the service yet these are considered pre-service appeals and you will receive a decision within 30 calendar days after receipt of your appeal request.

If you have already had the service these are considered post service appeals and you will receive a decision within 60 calendar days after receipt of your appeal request.

Denied appeal notice

If your appeal is denied, you will receive a written notice setting forth:

- The specific reason or reasons for the denial
- Reference to the specific plan provisions on which the denial is based
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits
- A statement explaining the external review procedures offered by the plan and your right to bring a civil action under ERISA section 502(a)
- A statement regarding any internal rule, guideline, protocol or other criterion that was relied upon in denying the claim (a copy of which will be provided free upon request)
- If the denial is based on a dental necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment that led to this determination (a copy of which will be provided free upon request)

Decisions upon the internal review are final under the plan's appeal process, and there are no further appeals available from Premera or Microsoft or any person administering claims or appeals under the plan. However, you still have a right to file suit under ERISA Section 502(a) as a result of the decision.

Limits on your right to judicial review

You must follow the appeals process described above through the decision on the appeal before taking action in any other forum regarding a claim for benefits under the plan. Any legal action initiated under the plan must be brought no later than one year following the adverse determination on the appeal. This one-year limitations period on claims for benefits applies in any forum where you initiate legal action. If a legal action is not filed within this period, your benefit claim is deemed permanently waived and barred.



If you have questions about understanding a denial of a claim or your appeal rights, you may contact Premera Customer Service for assistance at (800) 676-1411. You may also seek assistance from the Employee Benefits Security Administration (EBSA) of the U.S. Department of Labor at (866) 444-EBSA (3272).

Right to recover benefits paid in error

If Premera makes a payment in error on your behalf to you or a provider, and you are not eligible for all or a part of that payment, Premera has the right to recover payment, including deducting the amount paid mistake from future benefits.

Note: Health care providers are not "beneficiaries" of the plan, and although Premera may make direct payment to health care providers for the convenience of participants and their dependents, such payments of services shall not be considered "benefits" available under the plan, or confer beneficiary standing upon a health care provider.

Notice of information use and disclosure

Premera may collect, use, or disclose certain information about you. This protected personal information (PPI) may include health information, or personal data such as your address, telephone number, or Social Security number. Premera may receive this information from, or release it to, health care providers, insurance companies, or other sources.

This information is collected, used, or released for conducting routine business operations such as:

- Underwriting and determining your eligibility for benefits and paying claims
- Coordinating benefits with other health care plans
- Conducting care management, case management, or quality reviews
- Fulfilling other legal obligations that are specified under the Group Contract



Case management is a service to help ensure that you receive appropriate and cost-effective medical care. Review the [glossary](#) for a full definition.

This information may also be collected, used, or released as required or permitted by law.

To safeguard your privacy, Premera takes care to ensure that your information remains confidential by having a company confidentiality policy and by requiring all employees to sign it.

If a disclosure of PPI is not related to a routine business function, Premera removes anything that could be used to easily identify you or we obtain your prior written authorization.

You have the right to request inspection and/or amendment of records retained by Premera that contain your PPI.



Please contact the Premera Customer Service department at (800) 676-1411 and ask a representative to mail a request form to you.

Section VI: Flexible spending accounts (FSAs)

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How FSAs work

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Your FSA options

Flexible spending accounts (FSAs) can help you reduce your tax bill by letting you set aside pre-tax dollars to pay for eligible health care and dependent care expenses. If you are enrolled in the Health Savings Plan, your health care FSA participation is limited to vision and dental expenses (per IRS rules).

Account type	Eligibility	Expenses covered	Maximum contribution per year
Dental & Vision FSA	For employees with a Health Savings Account	Vision and dental only	\$2,550
Health Care FSA	For employees who don't have a Health Savings Account	Medical, prescription, dental, vision	\$2,550
Dependent Care FSA	For employees with eligible dependent care expenses	Child and elder care	\$5,000



If you leave Microsoft during the year, you will lose any remaining balance in your FSA accounts. However, you can extend the Dental & Vision FSA or Health Care FSA through COBRA coverage. For more information, see the [Coverage if you leave Microsoft](#) section.

When you enroll

You decide how much you would like to contribute to your FSA for the year, up to the maximum amount. You must reenroll during the open enrollment period each year if you want to continue participating in the next plan year.

The amount you elect will be deducted on a prorated basis each pay period throughout the year to fund your account. The following health care and dependent care FSA sections provide additional information about contributions.



Estimate your expenses carefully. The FSAs can reimburse only services that you use by December 31 of each year. All claims must be received by March 31 of the following year. The IRS allows you to carry over up to \$500 in unused funds to the following calendar year. Any remaining balance above \$500 is forfeited, pursuant to IRS rules.



To estimate your potential costs and tax savings under the FSAs, use the decision support tools on the [Benefits Enrollment tool](#).

Making changes

The annual open enrollment period is your only opportunity to make changes to your FSA elections unless you have a qualifying life event.

Changes to your election due to a qualifying life event will be effective as of the date requested, except for changes to health care FSA contributions resulting from a birth, adoption, or placement for adoption. If you increase your contribution, you may not be reimbursed for eligible expenses beyond your prior contribution if they occurred before the change.

Example

Melissa just had her second baby and changed her dependent care election from \$2,500 to \$5,000 on June 1. The plan will not reimburse expenses incurred before June 1 in excess of \$2,500.



For more information, see the [Life event enrollment](#) section.

Using your FSAs

To be eligible for reimbursement, expenses must meet IRS criteria and be incurred during the period of coverage. Services prior to your enrollment date are not eligible for reimbursement.

You pay for expenses and then seek reimbursement from your FSA. You may receive your reimbursement via direct deposit or check.



- To check the balance in your FSAs, visit [My Dashboard](#) on the Benefits site or contact Premera at (800) 676-1411
- For direct deposit of your reimbursements, complete the direct deposit form

You have 90 days from the end of the plan year to file claims for reimbursement for services received during the plan year. The IRS allows you to carry over up to \$500 in unused funds to the following calendar year. Any funds over \$500 over remaining in your FSA following 90 days after the end of the plan year will be forfeited, as required by IRS rules.



In accordance with Internal Revenue Service (IRS) regulations, health care or dependent care expenses from your domestic partner or your domestic partner's children are not eligible for reimbursement under this plan, unless they are filed as dependents on your tax return.

Please review the [health care](#) and [dependent care](#) FSA sections for more information about eligible expenses and the reimbursement process.

If you're on leave of absence

Payroll deductions for your health care or dependent care FSA will continue while you are on a paid leave of absence. For unpaid leaves of absence, payroll deductions that would have otherwise been taken during that period will be deducted from your first paycheck upon your return to work.

You may be reimbursed for eligible health care expenses during a paid or unpaid leave of absence. Your eligibility to be reimbursed for eligible dependent care expenses depends upon your particular leave situation. For more information, refer to IRS Publication 503.

If you change your election amount as part of a qualified life event while you are on leave, the new amount will be deducted from the first paycheck after the effective date of the change. For more information, see the [Life event enrollment](#) section.

If you are on leave for the entire annual open enrollment period, you will receive information in the mail, including an enrollment form. If you wish to continue your FSA participation, you must submit your election on the Benefit Enrollment tool or return the completed enrollment form by the end of the open enrollment period.

Health care FSA

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Contributions

You may contribute up to the IRS limit of \$2,550 to your health care FSA.



Estimate your expenses carefully. You must use all the money in your FSA by December 31 of each year or any remaining balance above the \$500 that the IRS allows you to carry over to the following calendar year is forfeited, as required by IRS rules. You have 90 days from the end of the year to file claims for reimbursement for services received during the plan year.

Eligible expenses

If you are enrolled in the Health Savings Plan, your health care FSA participation is limited to vision and dental expenses (per IRS rules). All other eligible employees may participate in the health care FSA, even if you are not enrolled in a Microsoft medical plan.



In accordance with Internal Revenue Service (IRS) regulations, health care expenses from your domestic partner or your domestic partner's children are not eligible for reimbursement under this plan, unless they are filed as dependents on your tax return.

To be eligible for reimbursement, expenses must:

- Meet the eligibility criteria defined under the Internal Revenue code. Examples of eligible expenses are provided in the following table.
- Be incurred during the FSA period of coverage
 - If your contributions begin after January 1 (for example, if you are a new hire), expenses incurred on or after your enrollment date are eligible for reimbursement
 - If your contributions end before December 31 (for example, due to termination of employment), expenses incurred after your last day of participation will not be eligible for reimbursement
 - Otherwise, your expenses must be incurred from January 1 to December 31

Account type	Eligibility	Examples of eligible expenses
Dental & Vision FSA	For employees with a Health Savings Account	<ul style="list-style-type: none"> • Dental expenses that are not fully covered by a group dental plan, including orthodontia

Health Care FSA	For employees who don't have a Health Savings Account	<ul style="list-style-type: none"> • Vision care and hardware, such as glasses, that are not fully covered by a group health care plan • Medical plan and dental plan deductibles • Coinsurance and copayments • Medical expenses that are not fully covered by a group medical plan (such as private duty nursing) • Dental expenses that are not fully covered by a group dental plan, including orthodontia and temporomandibular joint disorder (TMJ) • Vision or hearing care and hardware, such as glasses or hearing aids, that are not fully covered by a group health care plan • Lamaze classes for mother only
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For a complete list of eligible expenses, refer to IRS Publication 502. IRS Publication 502 does not mention: 1) that COBRA premiums *may not* be reimbursed from a Health Care FSA and 2) that certain over-the-counter medications *can be* reimbursed from a Health Care FSA if you have a prescription. Contact Premera at (800) 676-1411 for more information about these two reimbursements.

How to file a claim

You may be reimbursed for eligible health care expenses up to the total amount you have elected to contribute for the year, regardless of the amount contributed to the account to date.

If you participate in the Health Savings Plan or the Hawaii Only Plan, your eligible in-network expenses will be submitted automatically for reimbursement from your FSA, with the exception of the following:

- Claims for members with other coverage (COB)
- Claims for domestic partners or your domestic partner's children
- Sensitive claims for dependents (for example, mental health)



To update your account to manual claim submission, visit [Connect Your Care](#) on the Premera site.

For all other expenses, you have 90 days following the end of the plan year to submit claims to your FSA for reimbursement of expenses that were incurred the previous year. Claims that are submitted more than 90 days after the end of the plan year are not eligible for reimbursement and any funds left in the account will be forfeited.

Manual reimbursement

For manual reimbursement, you must submit the following to the address on the claim form:

- A completed claim form
 - Dental and Vision FSA Claim Form
 - Health Care Flexible Spending Account Claim Form
- Receipts or itemized bills for expenses that you or an eligible dependent incurred
- The explanation of benefits (EOB) that the health care plan provided if a portion of the expense was paid by a medical or dental plan



To submit your claim online, visit [My Dashboard](#) on the Benefits site.

Reimbursements are issued as either a check mailed to your home or, if you have direct deposit, an electronic funds transfer is initiated to your bank account.

Appeal for internal review

If the plan denies your claim, you may appeal for an internal review of the decision within 180 days of receiving the Explanation of Benefits (EOB).



An **appeal** is a written request to reconsider a written or official verbal adverse determination to deny, modify, reduce or end payment, coverage or authorization of health care coverage or eligibility to participate in the plan. This includes admissions to and continued stays in a facility. The process also applies to Flexible Spending Account appeals for reimbursement but does not apply to appeals of denied COBRA eligibility claims.



If you fail to file the internal appeal within 180 days of receiving the Explanation of Benefits, you will permanently lose your right to appeal the denied claim.

Submitting an appeal for internal review

You must provide the following information as part of your written appeal to the Premiera Appeals Department.

- Your name
- Your Premiera member number
- The name of this plan, and
- A concise statement of why you disagree with the decision, including facts or theories supporting your claim

Your written request may (but is not required to) include issues, comments, documents, and other records you want considered in the review.



The appeal should be submitted to Premera at the following address:

Appeals Coordinator
Premera Blue Cross
P.O. Box 91102
Seattle, WA 98111-9202

You may, at your own expense, have a representative act on your behalf. If you want to appoint someone to act for you in the appeals process (including your provider), you must submit a completed and signed [Premera Internal Appeals Authorization form](#) with your written appeal for internal review to the appeals coordinator at the address above.

Internal review and timeframe

All the information you submit will be taken into account on appeal, even if it was not reviewed as part of the initial decision. You may ask to examine or receive free copies of all pertinent plan documents, records, and other information relevant to your claim by asking Premera.

In the event any new or additional information (evidence) is considered, relied on or generated by Premera in connection with your appeal, Premera will provide this information to you as soon as possible and sufficiently in advance of the decision so that you will have an opportunity to respond. Also, if any new or additional rationale is considered by Premera, Premera will provide the rationale to you as soon as possible and sufficiently in advance of the decision so that that you will have an opportunity to respond.

If you have not had the service yet these are considered pre-service appeals and you will receive a decision within 30 calendar days after receipt of your appeal request.

If you have already had the service these are considered post service appeals and you will receive a decision within 60 calendar days after receipt of your appeal request.

Denied appeal notice

If your appeal is denied, you will receive a written notice setting forth:

- The specific reason or reasons for the denial
- Reference to the specific plan provisions on which the denial is based
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits
- A statement explaining the external review procedures offered by the plan and your right to bring a civil action under ERISA section 502(a)
- A statement regarding any internal rule, guideline, protocol or other criterion that was relied upon in denying the claim (a copy of which will be provided free upon request)

Decisions upon the internal review are the final decision under the plan's appeal process, and there are no further appeals available from Premera or Microsoft or any person administering claims or appeals under the plan. However, you still have a right to file suit under ERISA Section 502(a) as a result of the decision.

Limits on your right to judicial review

You must follow the appeals process described above through the decision on the appeal before taking action in any other forum regarding a claim for benefits under the plan. Any legal action initiated under

the plan must be brought no later than one year following the adverse determination on the appeal. This one-year limitations period on claims for benefits applies in any forum where you initiate legal action. If a legal action is not filed within this period, your benefit claim is deemed permanently waived and barred.



If you have questions about understanding a denial of a claim or your appeal rights, you may contact Premera Customer Service for assistance at (800) 676-1411. You may also seek assistance from the Employee Benefits Security Administration (EBSA) of the U.S. Department of Labor at (866) 444-EBSA (3272).

Right to recover benefits paid in error

If Premera makes a payment in error on your behalf to you or a provider, and you are not eligible for all or a part of that payment, Premera has the right to recover payment, including deducting the amount paid mistake from future benefits.

Note: Health care providers are not “beneficiaries” of the plan, and although Premera may make direct payment to health care providers for the convenience of participants and their dependents, such payments of services shall not be considered “benefits” available under the plan, or confer beneficiary standing upon a health care provider.

Notice of information use and disclosure

Premera may collect, use, or disclose certain information about you. This protected personal information (PPI) may include health information, or personal data such as your address, telephone number, or Social Security number. Premera may receive this information from, or release it to, health care providers, insurance companies, or other sources.

This information is collected, used, or released for conducting routine business operations such as:

- Underwriting and determining your eligibility for benefits and paying claims
- Coordinating benefits with other health care plans
- Conducting care management, case management, or quality reviews
- Fulfilling other legal obligations that are specified under the Group Contract



Case management is a service to help ensure that you receive appropriate and cost-effective medical care. Review the [glossary](#) for a full definition.

This information may also be collected, used, or released as required or permitted by law.

To safeguard your privacy, Premera takes care to ensure that your information remains confidential by having a company confidentiality policy and by requiring all employees to sign it.

If a disclosure of PPI is not related to a routine business function, Premera removes anything that could be used to easily identify you or we obtain your prior written authorization.

You have the right to request inspection and/or amendment of records retained by Premera that contain your PPI.



Please contact the Premera Customer Service department at (800) 676-1411 and ask a representative to mail a request form to you.

Dependent care FSA


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Contributions

Your dependent care FSA contribution cannot exceed the least of the following amounts:

- \$5,000 annually per household if you are married, filing jointly, or single and filing as head of household
- \$2,500 annually if you are married and filing separately
- The lesser of your or your spouse's earned income
- \$250 per month for one dependent or \$500 per month for two or more dependents up to the plan maximum (if your spouse is an unemployed, full-time student or incapable of self-care due to disability)



Estimate your expenses carefully. You must use all the money in your FSA by December 31 of each year or any remaining balance is forfeited, as required by IRA rules. You have 90 days from the end of the plan year to file claims for reimbursement for services received during the plan year.

Expenses reimbursed from your dependent care FSA cannot be used for the child and dependent care tax credit on your personal income tax return at the end of the year. In certain situations, it may be advantageous to use a combination of the tax credit and dependent care account, regardless of your income level. You should seek the opinion of a tax advisor regarding your personal financial situation.

Eligible expenses

Your dependent care expenses are eligible for reimbursement from your dependent care FSA if you and your spouse/domestic partner both work, or if your spouse/domestic partner meets one of the following criteria:

- Is a full-time student
- Is physically or mentally incapable of self-care

You may be reimbursed for eligible dependent care expenses for the following dependents:

- Your children age 12 and under that you claim as dependents for income tax purposes
- Older dependents, such as parents, who normally spend at least eight hours in your home each day, who are unable to care for themselves because of a disability, and whom you claim as dependents for income tax purposes

To be eligible for reimbursement, expenses must:

- Meet the eligibility criteria defined under the Internal Revenue code
- Be incurred during the same period in which amounts are credited to your FSA
 - If your contributions begin after January 1 (for example, if you are a new hire), expenses incurred on or after your enrollment date are eligible for reimbursement
 - If your contributions end before December 31 (for example due to termination of employment), expenses incurred after your last day of participation will not be eligible for reimbursement
 - Otherwise, your expenses must be incurred from January 1 to December 31

Examples of eligible expenses include:

- Childcare or baby-sitting services inside your home or someone else's home to enable both spouses to work
- Expenses for dependent care centers (that is, a center that cares for more than six people at a time and meets all state and local licensing requirements)
- Certain expenses for a full-time, live-in housekeeper to take care of your dependent who is age 12 or under or who is physically or mentally unable to care for him or herself
- School-related costs for your children who are not yet in kindergarten
- Expenses for summer day camps



For a complete list of eligible child and dependent care expenses, refer to IRS Publication 503.

How to file a claim

You may be reimbursed for eligible dependent care expenses up to the total amount you have elected to contribute for the year, regardless of the amount contributed to the account to date.

You have 90 days following the end of the plan year to submit claims for reimbursement of expenses that were incurred the previous plan year. Claims that are submitted more than 90 days after the end of the plan year are not eligible for reimbursement and any funds left in the account will be forfeited.

You must submit the following to the address on the claim form:

- A completed [Dependent Care FSA Claim Form](#)
- Receipts or itemized bills for expenses



To submit your claim online, visit [My Dashboard](#) on the Benefits site.

Reimbursements are issued as either a check mailed to your home or, if you have direct deposit, an electronic funds transfer is initiated to your bank account. You will receive an advance e-mail notification of the reimbursement to your Microsoft e-mail address.

Section VII: Other health & wellness benefits

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Microsoft Cares Employee Assistance Program (EAP)


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How the plan works

The Microsoft CARES (Counseling, Assistance, Referral, and Education Services) employee assistance program (EAP) provides a full range of high-quality, professional, and confidential services to help you and your family make important decisions and face life's challenges. Credentialed counselors and licensed therapists can help identify and initiate appropriate counseling for individual or family problems. Additionally, work-life consultants can help you prepare for major life events such as the birth of a child or planning vacations.



Microsoft respects your right to privacy in your personal and family life. No record of your use of the CARES program will be kept or made available to anyone within Microsoft. This also applies to your health care plans.

The CARES program is administered by Wellspring Family Services and is available to your benefits-eligible spouse/domestic partner and children. Microsoft pays 100% for this benefit.

- 
- To schedule an appointment with a CARES program counselor, call (206) 654-4144 or (800) 553-7798. You can also visit Microsoft CARES online (username MSCARES).
 - If you leave Microsoft or otherwise become ineligible, you will continue to have access to EAP benefits if you elect to continue medical plan coverage. For more information, see the [When coverage ends](#) section.

What the plan covers

The CARES program covers counseling services, new parent programs, and additional support services.

Counseling services

The table below outlines counseling services covered through the CARES program. Additional details on some of the counseling services follow the table.

Service	Description	Coverage
Individual counseling	Emotional, psychological, social, or work-related stress; brief problem resolution and/or referral for behavioral health treatment	Up to three sessions per member, per year
Individual telephonic counseling	For individuals who experience temporary issues and can benefit from additional consultation and support	Up to three sessions per member, per year
Couple/family counseling	For couples and/or families with issues related to relationship building, conflict resolution, and decision making within the family unit	Up to eight sessions per couple or family, per year, or emotional well-being aids and training as described below

The couple/family counseling sessions benefit may also be used to cover emotional well-being aids such as the EmWave Personal Stress Reducer (one device per family per year; each device counts as two of the three counseling sessions available).

You can also use the couple/family counseling sessions benefit to enroll in the following programs:

- The Gottman Institute's Art & Science of Love (up to 8 sessions per family, per year)
- Bringing Baby Home (up to 3 sessions per family, per year)
- Listening Mothers (up to 2 sessions per family, per year)
- Reflective Parenting (4 sessions per family, per year)
- The Gottman Institute's Emotion Coaching DVD to help raise emotionally healthy adolescents (one family session)



Additional mental health coverage may be available under your [medical plan](#).

Counseling services include:

Type of counseling	Description
Child counseling	You can get help for a child who needs to adapt more effectively within the family, at school, and with friends. Experienced child counselors lead individual and group sessions.
Domestic violence treatment program	Education and support is available for men or women trying to overcome the cycle of violence and abuse. Classes and group sessions focus on assessing domestic violence issues, changing abusive behaviors, and learning nonviolent relationship skills.
Grief counseling	Counseling is available for adults and children who have experienced the death of a loved one. Support groups and referral sources are also available.
Work-related and onsite resources	Support is available for managers who may be dealing with difficult situations in their work environment, including conflict resolution, communicating sensitive messages, and dealing with deaths in the workplace.
Couples workshop	In partnership with Wellspring Family Services, the Gottman Institute offers you and your spouse/domestic partner a workshop titled The Art and Science of Love: A Weekend Workshop for Couples. This two-day weekend couples workshop is designed to strengthen your marriage or partnership, and will give you new insights and research-based relationship skills that can help improve your relationship and resolve conflict in a healthy, productive way.



For more information about the weekend couples workshop, call the Gottman Workshop Registration telephone line at (206) 431-5423, or go online to Microsoft CARES (username MSCARES) or the Gottman Institute.

New parent programs—(Seattle/Redmond area only)

Listening Mothers

This is a small group program for new mothers and their babies (up to nine months old) designed to ease the adjustment to parenthood. Led by a trained facilitator, groups meet weekly for 1.5 hours over an eight-week period to explore the complex range of emotions of motherhood. Listening Mothers helps lay the foundation for healthy, loving relationships between mothers and babies; it can:

- Deepen your self-awareness and build your self-confidence in your interactions with your baby
- Develop your identity as a new mother
- Increase your ability to guide your baby through the steps of normal emotional development

Bringing Baby Home

Created by relationship experts, Drs. John and Julie Gottman, Bringing Baby Home is a workshop designed to teach pregnant and parenting couples how to maintain or increase their relationship satisfaction after becoming parents. Couples are encouraged to register for this course in the second or third trimester of pregnancy, or during the first year after their baby arrives.

Beyond the Baby Blues

Beyond the Baby Blues is a program that promotes increased awareness and provides treatment for pregnancy and postpartum mood disorders, and supports the adjustment to parenthood.

Parent-Infant Counseling

The first few years of your baby's development are essential to the rest of his/her life. By strengthening your relationship with your baby, specialists help you create the social and emotional health your child needs to thrive. Come work together as a family with our team of parent-infant emotional development specialists.

Reflective Parenting

Reflective parenting groups help parents explore their children's thoughts, feelings and motivations as well as their own. This process helps parents better understand and respond to their child's behavior in appropriate and sensitive ways.

Additional support services and resources

The CARES program also offers the following resources:

Services	Description
Optimize Your Energy Stress Center	A stress management and prevention center with tools to help you deal with stress as it happens or make pro-active lifestyle changes to manage stress.

Services	Description
Work-life tools	Online tools, articles, audio/video information, resources, and skill builders that provide practical tips on parenting, aging, balancing, thriving, working, living, as well as U.S./international immigration/relocation.
Webinars	Monthly and on-demand webinars with topics ranging from strengthening your communication skills to celebrating mid-life; traveling like a travel agent; creating a great workplace, and more.
Live Connect	Live chat with an expert about childcare, elder care, or how to manage daily living issues such as home/auto repair, running errands, vacation planning, and pet sitting.
Childcare resources	Resources, articles, legal forms, seminars, and skill builders for parenting, adoption, childcare, education, and more. Assisted Search will now confirm openings for you.
Elder care assistance	Resources, articles, legal forms, seminars, and skill builders for topics relating to adults with disabilities, aging well, planning for the future, government programs, housing options, home care, caregivers and grief and loss.



For more information on Microsoft CARES services and resources, or to schedule an appointment, call (206) 654-4144 or (800) 553-7798 or go to Microsoft CARES online (username MSCARES).

24-Hour Nurse Line

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How the plan works

The Microsoft 24-Hour Nurse Line is a confidential health-care information service for you and your dependents. The Nurse Line is available 24 hours a day, seven days a week. It provides useful, easy-to-understand health-care information that will help you to make appropriate health-care decisions.

The nurses who staff the 24-Hour Nurse Line have an average of 10 years of experience. The nurses cannot diagnose illnesses, prescribe treatment, or give medical advice, but they can do the following:

- Provide information, coaching, and support regarding a wide range of health issues, including:
 - Aches and pains
 - Diabetes
 - High blood pressure
 - Illnesses and infections
 - Infant care
 - Immunizations
- Provide information about Microsoft-sponsored health programs such as:
 - Disability leave
 - Ergonomic assistance
 - On-site flu shots
 - On-site mammogram screenings
 - Smoking cessation
 - Weight management
- Offer suggestions about appropriate next steps or available resources.

The average call to the 24-Hour Nurse Line lasts approximately five minutes, so that you can obtain information quickly and can move on to the next step, as advised by the 24-Hour Nurse Line nurse.

The 24-Hour Nurse Line is a service provided by Premiera Blue Cross. All Microsoft benefits-eligible employees and their dependents, including those covered by the HMO Plan (Group Health Cooperative), can access the 24-Hour Nurse Line.

Accessing the 24-Hour Nurse Line

The toll-free phone number for the 24-Hour Nurse Line is a consolidated phone line. From this one number, Microsoft benefit-eligible employees and their dependents can access several health-care services, such as the 24-Hour Nurse Line staff of nurses, a professional counselor with the Microsoft Counseling, Assistance, Referral and Education Services (CARES) Employee Assistance Program, flexible spending account (FSA) information, and health-care coverage information. When you call, listen carefully to the entire greeting before you make your selection.



You can reach an experienced, registered nurse 24 hours a day, seven days a week by calling one of the following options:

- (800) 676-1411
- For deaf or hard-of-hearing access, call the TTY service and provide the previously mentioned number

For more information about the 24-Hour Nurse Line, contact Benefits.

Expert Medical Option (Best Doctors)

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How the plan works

Microsoft's Expert Medical Opinion Program, administered by Best Doctors, an independent third-party vendor, offers expert medical advice when you or your eligible dependents (including parents who are otherwise ineligible for coverage or benefits under the Plan) are facing an important medical decision. The Expert Medical Opinion Program is available to help whether you are contemplating a surgery decision or trying to confirm a diagnosis of a condition such as cancer or other complex medical issues. The Expert Medical Opinion Program is a voluntary and confidential service provided at no additional cost to all Microsoft U.S. benefits-eligible employees and their eligible dependents.

The program offers the following three services:

- **In-Depth Medical Review.** An in-depth medical review is appropriate when a diagnosis of a condition is in question, or you're looking for the best ways to treat a complicated condition. This service provides an extensive review of your medical records and tests by a nationally recognized expert. Bringing another expert to the table can help you and your current doctor consider another perspective or give you confidence in your current plan of treatment.
- **Ask the Expert.** When you want answers from a specialist physician to basic questions about health conditions and treatment options.
- **Find a Doctor for Your Condition.** When you need additional help to find a leading, recognized physician in your local area network.

You can access these services with a phone call to the Expert Medical Opinion Program at (800) 676-1411, option 5.

In-Depth Medical Review

- To get started, call (800) 676-1411. A dedicated Best Doctors Member Advocate will conduct an in-depth discussion with you about your medical condition, including obtaining a full health history of you and your family.
- After the discussion, following your written authorization, Best Doctors will gather medical records concerning your present condition and diagnosis.
- When the records are received, the Best Doctors clinical team will analyze your clinical information and select the appropriate expert(s) for your medical condition to evaluate your case.
- Your Member Advocate will send you a report of the expert's findings, summarized in an easy-to-read format, as well as a comprehensive expert report for your treating physician's reference.

- Your Member Advocate will speak with you about the report's findings and then, provided that you authorize it, delivers the report to your treating physician.
- Throughout the process, your dedicated Member Advocate is available to answer your questions. At both six weeks and six months after you receive the report, your Member Advocate will follow up to see if you need any other help.

Ask the Expert

- To get started, call (800) 676-1411. A dedicated member of the Best Doctors clinical team will conduct an in-depth discussion with you to gather any necessary medical information and determine the questions you want answered.
- Your questions and unique medical information will be sent to an expert physician for review.
- You'll receive a comprehensive report containing the expert's findings, including suggestions for treatment options.

Find a Doctor for Your Condition

- To get started, call (800) 676-1411. A member of the Best Doctors clinical team will gather some basic information from you, so they can make sure they recommend the right doctor for your situation. They will take into account your age, medical history and other health conditions, and ask if you have any requests for location, experience, gender or specialized expertise.
- Best Doctors will call each doctor's office to confirm that the physician accepts your medical plan and is taking new patients.
- They'll provide you with a list of doctors who match your criteria, giving you the flexibility to choose a physician and schedule an appointment that works for you.



Although the Expert Medical Opinion Program is provided at no additional cost to you, any treatment or services contained in your Best Doctors expert report will be paid according to the provisions of your selected medical plan. Prior to receiving any additional treatment or service, review the coverage details of your medical plan or contact Premera at (800) 676-1411 or Group Health Cooperative at (888) 901-4636.

Eligibility and Exclusions

All U.S. benefits-eligible employees and their eligible dependents (including parents, who are otherwise ineligible for coverage or benefits under the Plan) can take advantage of the Expert Medical Opinion Program. Certain types of cases cannot be reviewed by Best Doctors. Cases of mental health disorders that do not have physical ailments are not serviced by Best Doctors as there is insufficient data contained within the records to perform an informed analysis, and in-person evaluations are more appropriate. Additionally, the Expert Medical Opinion Program does not provide consulting services for cases being covered under Workers Compensation. If you are unsure if your case can be reviewed by Best Doctors, call (800) 676-1411.



For more information about the Expert Medical Opinion Program (Best Doctors), call (800) 676-1411, option 5.



Best Doctors will NOT share your medical records, medical information or the contents of your Best Doctors report with anyone, including Microsoft or your health plan, unless you specifically authorize such disclosure. In addition, Best Doctors endeavors to comply with all relevant state, national, and international laws and regulations including the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Unless required by law, your specific name and medical information will NOT be shared with anyone, including Microsoft, without your written consent. Only de-identified and aggregate information will be used for program evaluation and improvement purposes.

Section VIII: Employee and dependent life insurance

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Employee life insurance

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How the plan works

Employee life insurance provides financial security to your beneficiaries in the event of your death. Information about your coverage options through Prudential and what you pay is provided in the table below.

Amount of coverage	What you pay
You may elect life insurance in the amount of one to 10 times your annual base pay, up to a maximum of \$1,500,000, whichever is less.	<ul style="list-style-type: none"> Microsoft pays for the cost of insurance that is equal to two times your annual base pay. The value of this coverage above \$50,000 is considered taxable income to you. You may purchase additional employee life insurance coverage using post-tax dollars. Coverage rates are provided in the Benefits Enrollment tool and depend on your age and the amount of coverage you elect.



The IRS regulates the taxable value of life insurance coverage above \$50,000. The IRS taxable value will appear as taxable income on your annual W-2 form and will be reflected on your Microsoft payroll check stubs as W2GRP. How this impacts your Federal Income and Social Security taxes will depend on your age, tax situation, and the amount of Microsoft paid life insurance over \$50,000 you elect.

Your coverage will be based on your annual base pay as of the first day of the calendar year for coverage elected during the annual open enrollment period. For employees hired during the calendar year, coverage will be based on your annual base pay as of the first day of enrollment. Annual base pay is defined as follows:

Employee type	Definition of annual base pay
Full-time salary employee	Base salary (not including bonus)
Full-time hourly employee	Hourly wage multiplied by 2080
Part-time hourly employee	Hourly wage multiplied by regularly scheduled hours in a year

Certain coverage levels may require evidence of insurability before your coverage election takes effect. Choose your level of coverage carefully, as you may not make changes to your coverage level outside of the annual open enrollment period. However, your life insurance coverage amount will automatically change as your pay changes. These changes to your life insurance coverage will be effective the first day of the month following the change of your base pay.



For more information about the benefits covered under the Microsoft employee and dependent life insurance plans, see the [Employee & Dependent Life Insurance Certificate](#). If you have additional questions, contact Benefits.



All benefits and coverages described in this plan description are subject to the terms of the insurance policies under which the benefits are provided. If there is any conflict between this summary and the insurance policies, the insurance policies will always govern.



If you leave the company or become otherwise ineligible for coverage, you have the right to apply for continued life insurance coverage. For more information, see the [Coverage if you leave Microsoft](#) section.

Evidence of Insurability (EOI)

Prudential may require satisfactory evidence of insurability (EOI) if one of the following criteria applies:

- You are a new employee, and you elect coverage exceeding \$500,000
- You increase coverage by more than one time your base pay during annual open enrollment
- You elect more than \$500,000 in coverage during annual open enrollment
- You request any increase in coverage after having previously provided unsatisfactory EOI to Prudential

The EOI form is accessible via the [Benefits Enrollment tool](#). You will need to complete and return this medical history questionnaire to Prudential within 30 days.



If you do not complete and return an EOI form to Prudential within 30 days of making your election, your coverage will be set at an amount that does not require EOI.



To contact Prudential directly, e-mail microsoft@prudential.com or call (800) 778-3827 or TDD (800) 493-1214.

Assignment of your life insurance rights

You may assign your life insurance to another person or entity (such as a trust) as a gift, including any right you have to choose a beneficiary or to convert to another contract of insurance. If you wish to do this, you will need to alert Prudential of this assignment and the contract holder. This assignment is irrevocable.

If you become disabled

Prudential will waive your employee life insurance premiums if you become disabled, provided your disability meets all of the following criteria:

- You became disabled before your sixtieth birthday and while insured for life insurance under this policy
- You have been continually disabled for nine months
- Your disability results from sickness or injury and occurs while you are insured

- Your disability prevents you from performing the material and substantial duties, for wage or profit, of any job for which you are reasonably suited by education, training, or experience

Prudential must receive notice and proof of your disability within 12 months after you have been continuously disabled. Prudential must also receive annual written medical proof that you remain disabled. Prudential may, at its own cost, require you to have physical examinations as often as is reasonably required while a claim is pending.

The waiver of life insurance premiums will end on the date that you meet any of the following criteria:

- Are no longer disabled
- Fail to submit proof that disability continues
- Refuse to be examined when required by Prudential
- Reach the age of 65

If your insurance ends due to your employment ending, you may convert your Microsoft coverage to a self-paid policy under life coverage if both of the following criteria apply:

- Your waiver of premium ends and you do not return to active work within 31 days, and
- Your insurance does not continue

If you have converted to an individual life insurance policy, and Prudential later approves your waiver of premium claim, Prudential will cancel the conversion policy and refund any conversion policy premiums you have paid.



For more information, see the [Coverage if you leave Microsoft](#) section.

How the plan pays

In the event of your death, benefits will be paid as a lump sum to your beneficiaries according to the following guidelines:

- If you name two or more beneficiaries, each will receive an equal share of your life insurance benefit payment unless you indicate a different payment method in the Benefits Enrollment tool. In addition, if a beneficiary dies before you, that portion of your benefit will be divided equally among the beneficiaries who survive you.
- If the beneficiary is a minor or otherwise incapable of giving a valid release, Prudential will pay the benefit according to state laws governing payments to minors
- If there is no living named beneficiary, Prudential will pay the employee's estate or, at Prudential's option, to any one or more of these surviving relatives of the dependent:
 - Your surviving spouse/registered domestic partner
 - Your surviving child (children)
 - Your surviving parents
 - Your surviving siblings



It's important to keep your beneficiary designations up to date. Prudential will make a payment only to the most recently named beneficiary or beneficiaries.



A beneficiary is the person(s) named as the recipient of the plan benefits in the event of your death.



To select or change your beneficiary, use the [Benefits Enrollment tool](#).

Accelerated payment

If you become terminally ill while insured under the plan, you can request benefit payment before your death. Prudential will pay 75% of the benefit, up to a maximum of \$500,000, in a lump sum or in 24 monthly installments. The amount will be paid to you and remaining benefits will be reduced by this accelerated payment.

Prudential will pay the accelerated benefit only if:

- You complete and submit a claim form provided by Prudential
- You provide a doctor's certification indicating that your life expectancy is 24 months or less. Your doctor will need to complete the Attending Physician's Certification part of the claim form. If Prudential disagrees with a doctor's certification, you have the right to mediation or binding arbitration conducted by an independent third party.
- Your employee term life insurance has not been assigned
- Terminal illness proceeds will be made available to you on a voluntary basis only. You are not eligible if you elect the benefit involuntarily to meet the claims of creditors and others.

Premium contributions must continue for the remaining benefit until the earlier of one of the following:

- The date you are no longer eligible for coverage
- The date that Microsoft coverage under this policy ends
- If it appears to Prudential that a person incurs expenses in connection with your last illness, death or burial, that person may receive part of your Optional Employee Term Life Insurance. Prudential, at its option, may pay that person up to the greater of: (a) 10% of the amount for which you are insured, and (b) \$1,000. If an amount is so paid, Prudential will not have to pay that part of your insurance again.



The accelerated benefit may be taxable. You should seek assistance from a personal tax advisor since reporting and consequences are the sole responsibility of the recipient of the benefit funds.



There are state-specific requirements that may change the provisions under the Coverage(s) described in this Group Insurance Certificate. If you live in a state that has such requirements, those requirements will apply to your Coverage(s) and are made a part of your Group Insurance Certificate.

To review these state-specific requirements, visit Prudential's website at www.prudential.com/etonline. You will need to enter your state of residence and Access Code 43994.

Dependent life insurance

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How the plan works


Dependent life insurance helps support your family in the event of a death in your family. Information about your coverage options through Prudential and what you pay are provided in the table below.


Amount of coverage	What you pay
<ul style="list-style-type: none">• Spouse/domestic partner life insurance from \$5,000 to \$500,000 (not to exceed 50% of the coverage of your employee life insurance election)• Dependent child life insurance in the amounts of \$5,000, \$10,000 or \$15,000 (for each child under age 26)	<ul style="list-style-type: none">• You may purchase optional dependent life insurance coverage using post-tax dollars. Coverage rates are provided in the Benefits Enrollment tool and depend on the amount of coverage you elect and your age.


Certain coverage levels may require evidence of insurability before your dependents’ coverage elections take effect. You may not make changes to your coverage level outside of the annual open enrollment period unless you experience a qualifying life event. If a dependent is confined for medical care or treatment, any increases in the dependent’s life insurance will be delayed until a final medical release from confinement is received. This limitation does not apply to your newborn child.

 For a list of qualifying life events, see the [Life event enrollment](#) section.

Payments may be accelerated if your dependent spouse/domestic partner becomes terminally ill. Benefits are paid to you upon death of your covered dependent(s) from any cause.

 For more information about the current benefits that are covered under the Microsoft employee and dependent life insurance plans, see the [Employee & Dependent Life Insurance Certificate](#). For further questions, contact Benefits.

 *All benefits and coverages described in this plan description are subject to the terms of the insurance policies under which the benefits are provided. If there is any conflict between this summary and the insurance policies, the insurance policies will always govern.*

 *If you leave the company or become otherwise ineligible for coverage, you have the right to apply for continued life insurance coverage for your covered dependent. For more information, see the [Coverage if you leave Microsoft](#) section.*

Evidence of Insurability (EOI)

Depending on the level of coverage you elect, Prudential may require satisfactory evidence of insurability (EOI). The EOI form is accessible via the Benefit Enrollment tool. You will need to complete and return this medical history questionnaire to Prudential within 30 days of making the following elections:

- You elect coverage of more than \$100,000 for your spouse or domestic partner
- You increase coverage during annual open enrollment
- You increase coverage due to a qualifying change in employment or family status



If you do not complete and return an EOI form to Prudential within 30 days of making your elections, your coverage will be set at an amount that does not require EOI.

Assignment of your life insurance rights

You may assign your dependent life insurance to another person or entity (such as a trust) as a gift, including any right you have to choose a beneficiary or to convert to another contract of insurance. If you wish to do this, you will need to alert Prudential of this assignment and the contract holder.

How the plan pays

Benefits are paid to you upon the death (from any cause) of a covered spouse or domestic partner, or dependent child. You may receive the plan payment in a lump sum.

Accelerated payment

If your spouse/domestic partner becomes terminally ill, you may request accelerated payment of your dependent life insurance benefits. Prudential will pay 75% of the benefit, up to a maximum of \$500,000. Benefits will be paid as a lump sum and remaining benefits will be reduced by the accelerated payment.



You or your spouse/domestic partner can only receive the accelerated benefit once. This benefit is not available for child dependents.

Prudential will pay the accelerated benefit only if:

- You complete and submit a claim form provided by Prudential.
- Your spouse or domestic partner benefit is not assigned.
- You must provide a certification by a doctor that your spouse or domestic partner's life expectancy is 24 months or less. The doctor will need to complete the Attending Physician's Certification part of the claim form. If Prudential disagrees with a doctor's certification, you have the right to mediation or binding arbitration conducted by an independent third party.
- Terminal illness proceeds will be made available on a voluntary basis only. You are not eligible if you elect the benefit involuntarily to meet the claims of creditors and others.

Premium contributions must continue for the reduced benefit amount until the earlier of the date that:

- You are no longer eligible for spouse or domestic partner coverage
- Microsoft coverage under this policy ends
- Spouse or domestic partner coverage for an entire class ends
- This policy ends



The accelerated benefit may be taxable. You should seek assistance from a personal tax advisor since reporting and consequences are the sole responsibility of the recipient of the benefit funds.



There are state-specific requirements that may change the provisions under the Coverage(s) described in this Group Insurance Certificate. If you live in a state that has such requirements, those requirements will apply to your Coverage(s) and are made a part of your Group Insurance Certificate.

To review these state-specific requirements, visit Prudential's website at www.prudential.com/etonline. You will need to enter your state of residence and Access Code 43994.

Section IX: Accidental death & dismemberment (AD&D)

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How the plan works

Accidental death and dismemberment (AD&D) insurance protects you and your family in the event of an accident-related death or injury that causes the loss of limbs or certain senses. This is an optional benefit provided through Prudential and doesn't require evidence of insurability (proof of good health).

You may purchase coverage for yourself and/or your eligible dependents using pre-tax dollars. Coverage rates are provided in the Benefits Enrollment tool and depend on the amount of coverage you elect.

Information about your coverage options is provided in the table below. The amount of coverage you elect for yourself determines the amount that is available to your eligible dependents. Child dependents are covered to age 26.

Beneficiaries	Coverage
You (Microsoft employee)	One to 10 times your annual base pay, up to a maximum of \$1,500,000, whichever is less.
Spouse/domestic partner only	65% of employee coverage, up to a \$500,000 maximum
Spouse/domestic partner and children	For spouse/domestic partner, 50% of employee coverage amount, up to a \$500,000 maximum For each child, 15% of employee coverage amount, up to \$75,000 maximum
Children only	For each child, 25% of employee coverage amount, up to \$75,000 maximum

Your coverage will be based on your annual base pay as of the first day of the calendar year for coverage elected during the annual open enrollment period. For employees hired during the calendar year, coverage will be based on your annual base pay as of the first day of enrollment. Annual base pay is defined as follows:

Employee type	Definition of annual base pay
Full-time salary employee	Base salary (not including bonus)
Full-time hourly employee	Hourly wage multiplied by 2080
Part-time hourly employee	Hourly wage multiplied by regularly scheduled hours in a year

Because your AD&D coverage is based on your pay, your coverage will change automatically as your pay changes. These changes to your AD&D insurance coverage will be effective the day your pay changes as long as you are actively at work, or you return to work. You may change your coverage level only during the annual open enrollment period or if you have a qualifying life event.

All AD&D benefits are subject to the plan's [Exclusions and limitations](#). Each benefit may have additional eligibility criteria and exclusions and limitations. More information on what is covered is provided on the following pages.



For more information about conditions of coverage and payable benefits, see the [Employee and Dependent AD&D Certificate](#).



All benefits and coverages described in this plan description are subject to the terms of the insurance policies under which the benefits are provided. If there is any conflict between this summary and the insurance policies, the insurance policies will always govern.



You have a right to apply for continued AD&D coverage through the Portability Plan for you or your covered dependents if your coverage ends because you leave Microsoft or otherwise become ineligible. For more information, see the [Coverage if you leave Microsoft](#) section.

How the plan pays

Benefits are payable if you—or a covered dependent—die or suffer certain serious injuries as the direct result of a covered accident. Benefits are paid to your designated beneficiary upon your death. If a covered dependent dies, you are the beneficiary.



A beneficiary is the person(s) named as the recipient of the plan benefits in the event of the member's death or injury.



To update your beneficiary information, use the [Benefits Enrollment tool](#).

Benefits will be paid as a lump sum according to the following guidelines:

- If a covered dependent dies, you are the beneficiary of any amounts paid from the plan
- If you die in a covered accident, AD&D benefits are paid to your named beneficiaries. Contingent beneficiaries will receive the plan benefits if the primary beneficiary dies while you are living.
- If you name two or more beneficiaries, each will receive an equal share of your AD&D benefit payment—unless you indicate a different allocation. If a beneficiary dies before you, that portion of your benefit will be divided equally among the beneficiaries who survive you.
- If you do not name a beneficiary or do not have current beneficiary information on file, your AD&D benefit would be payable to the first survivor on the following list:
 - Your spouse/domestic partner
 - Your children, in equal shares
 - Your parents, in equal shares
 - Your brothers and sisters, in equal shares
 - Your estate

If you are age 70 or older, your benefits will be reduced according to the following schedule:

Reduction schedule	
Age	Coverage
Age 69 or younger	100% of coverage amount
70-74	65% of coverage amount
75-79	45% of coverage amount
80-84	30% of coverage amount
85 and older	15% of coverage amount

What the plan covers

The following table indicates the percentage of your coverage that is payable in the event of your death or injury due to a covered accident. A percentage of these amounts would be payable for similar losses suffered by a covered dependent. Coverage for your dependent depends upon whether you elected family tier coverage and your family structure. See the beneficiary table in the [How the plan works](#) section for more information. Additional benefits, such as counseling and childcare, are provided following the table.



Benefits are not payable for injury or death from certain events described in the plan's [Exclusions and limitations](#). Benefits must be claimed within 365 days after the date of the accident.

Loss	Benefit (percentage of coverage purchased)
Life (see additional benefit details below)	100%
Sight in both eyes (total and permanent)	100%
Speech and hearing in both ears (total and permanent)	100%
Both hands	100%
Both feet	100%
One hand and one foot	100%
One hand and sight in one eye	100%
One foot and sight in one eye	100%
Both arms and both legs (Quadriplegia)	100%
Both arms and one leg or both legs and one arm (Triplegia)	75%
Both legs (Paraplegia)	75%
One arm and one leg (Hemiplegia)	66.6%
Sight of one eye (total and permanent)	50%
One arm or one leg (Uniplegia)	50%
Speech (total and permanent)	50%
Hearing in both ears (total and permanent)	50%
One hand	50%

Loss	Benefit (percentage of coverage purchased)
One foot	50%
Thumb and index finger of the same hand	25%
Loss of hearing in one ear (total and permanent)	25%
Coma (see additional criteria below)	1% per month, up to 100 months

Example

Marissa is in a car accident and loses her foot. She has elected coverage of 3 times her salary of \$80,000, which is \$240,000. The AD&D plan pays 50% for the loss of a foot, so she would receive a lump sum payment of \$120,000 (\$240,000 x 50%).



- Total loss of use must be determined by a licensed physician to be permanent, complete, and irreversible
- A benefit is not payable for both loss of thumb and index finger of the same hand and the loss of one hand as the result of any one accident
- In no event will the total of all benefits payable under the above benefits exceed your amount of AD&D coverage

Additional benefits

Bereavement and trauma counseling

The plan pays up to \$50 per visit for up to 50 visits for bereavement and trauma counseling if it is:

- Required because of a loss
- Provided within one year of the loss

Additional counseling benefits may be provided under your [medical plan](#) or the [Microsoft CARES employee assistance plan \(EAP\)](#).

Child's injury

If a child who is covered by AD&D insurance suffers a loss other than a loss of life, you will receive an additional benefit equal to the lesser of 200% of the amount payable or the one largest amount to which the child is entitled and \$75,000. This benefit is not payable if the child dies within 90 days of the accident.

Childcare

If you or your insured spouse/domestic partner dies in a covered accident, an additional benefit is paid to cover childcare expenses. Eligible children must:

- Be under the age of 13
- Be covered under AD&D insurance
- Be enrolled at a childcare center or become enrolled at a childcare center within 90 days after the covered accident

The benefit is the lesser of \$5,000, the actual cost charged by the childcare center, or five percent of the benefit amount for the member whose loss of life is the basis of the claim. Benefits are payable each year that the child is enrolled in a childcare center until the age of 13 or a maximum of four years of payment.

This benefit is payable only if the childcare center is a facility or individual that operates pursuant to law, if locally required, is not a family member, and that primarily provides care and supervision for children in a group setting on a regular, daily basis.

If no dependent children qualify, a lump sum amount of \$3,000 will be paid to your beneficiary or beneficiaries. The benefit is paid only once, either for the loss of your life or that of your spouse/domestic partner, but not for both.

Coma

If you or your covered eligible dependent lapse into a coma as the result of a covered accident, an amount of up to 100 percent of the full AD&D benefit will be paid in installments of 1 percent per month. To be eligible for this benefit, coma must:

- Occur within one year of a covered accident
- Continue for one month
- Be diagnosed to be total, continuous, and permanent at the end of that 31-day period.

Continuation of medical coverage

If you must take a leave of absence from work or your employment ends as a result of a covered loss, you may receive payments to help you pay for continuation of medical coverage through COBRA for 24 months. Payments will stop if you become covered under another medical plan. Each payment will equal the lesser of 3% of your benefit or \$125. Proof that the payment will be used for continuation of medical coverage will be required. For more information on continuation of medical coverage, please review the [Coverage if you leave Microsoft](#) section.

Felonious assault

If you suffer a loss that is the result of a felonious assault, the benefit amount payable will increase by an amount equal to the lesser of 5% of the benefit or \$5,000. The assault must occur:

- Because of your employment and while you are working for Microsoft
- On an authorized business trip

Home alteration and vehicle modification

In the event of a loss that requires home alteration or vehicle modification, you may receive an amount equal to the lesser of:

- The actual cost of the alteration or modification
- 5% of your benefit amount
- \$2,000

Loss of life

If you or your covered spouse/domestic partner suffers a loss of life due to a covered accident, an additional benefit equal to 1% for six consecutive months will be paid to the surviving spouse/domestic partner; if there is no spouse/domestic partner, then the benefit will be paid to the dependent children. No benefit is payable if there is no surviving spouse/domestic partner or child.

If you and your covered spouse/domestic partner both suffer loss of life due to covered injuries by the same accident or separate accidents within 48 hours of each other, the benefit amount payable to your surviving dependent child or children of your spouse/domestic partner will be the lesser of the difference between (1) the amount payable for your loss of life and the amount payable for your spouse/domestic partner's loss of life; and (2) \$500,000. This benefit is available if you elect AD&D coverage for yourself, spouse/domestic partner and dependent children.

Rehabilitation

If within one year and as a result of a covered accident, a doctor determines that you or your covered eligible dependent require necessary training to help you return to normal activities, a monthly benefit of 1% of your benefit amount, subject to a maximum of \$500 per month, will be paid for up to 24 months while you need rehabilitation. This benefit will cease if you do not furnish proof of the continuing need for the rehabilitation or fail to undergo a doctor's examination requested by Prudential. Additional rehabilitation benefits may be provided under your [medical plan](#).

Safe driving

If you or a dependent dies from an injury while driving or as a passenger in an automobile, your benefit will be increased by the lesser of 10% or \$25,000 if the member was wearing a properly fastened seat belt and/or protected by a side air bag.

This benefit is not paid if the death results from the following:

- Driving or riding in an automobile used in a race or a speed or endurance test, for acrobatic or stunt driving or for any illegal purpose

Tuition benefits

If you or your insured spouse/domestic partner dies in a covered accident, certain dependent children can continue their education. The lesser of 5% of your benefit or \$5,000, or the actual annual tuition fee (excluding room and board) will be paid per year for up to four consecutive years. Eligible dependent children include:

- Your child who wholly depends on you for support and maintenance on the date of death; and
- Children below the age of 25 enrolled as a full-time student in a university, college, or trade school
- Children in the 12th grade who enroll as a full-time student in a university, college, or trade school within 365 days after the insured individual's death

If no dependent children qualify, a lump sum benefit of \$3,000 will be paid. The benefit is paid only once, either for the loss of your life or that of your spouse/domestic partner, but not for both.

If you die in a covered accident, your AD&D insured spouse/domestic partner will be paid a tuition reimbursement benefit if he or she enrolls in a professional or trade program within 30 months after the date of death for the purposes of obtaining an independent source of support or enriching his or her ability to earn a living. The benefit will equal the lesser of 5% of your benefit, \$5,000, or the actual tuition amount and is payable for one year.



For more information about conditions of coverage and payable benefits, see the [Employee and Dependent AD&D Certificate](#).



There are state-specific requirements that may change the provisions under the Coverage(s) described in the Group Insurance Certificate. If you live in a state that has such requirements, those requirements will apply to your Coverage(s) and are made a part of your Group Insurance Certificate.

Prudential has a website that describes these state-specific requirements. You may access the website at <http://www.prudential.com/etonline>. When you access the website, you will be asked to enter your state of residence and your Access Code. Your Access Code is 43994.

Exclusions and limitations

This plan does not cover any loss caused by or resulting from the following:

- Suicide or attempted suicide while sane or insane
- Intentionally self-inflicted injuries, or any attempt to inflict such injuries
- Sickness, whether the loss results directly or indirectly from the sickness
- Medical or surgical treatment of sickness, whether the loss results directly or indirectly from the treatment
- Any bacterial or viral infection; however, this exclusion does not include a pyogenic infection resulting from an accidental cut or wound; or a bacterial infection resulting from accidental ingestion of a contaminated substance
- Taking part in any insurrection
- War or any act of war, except as provided by any War Risk Hazard provision; war refers to declared or undeclared war and includes resistance to armed aggression
- An accident that occurs while the person is serving on full-time active duty for more than 30 days in any armed forces. However, this does not include Reserve or National Guard active duty for training.
- Travel or flight in any vehicle used for aerial navigation in any of the following cases:
 - The person is riding as a passenger in any aircraft not intended or licensed for the transportation of passengers
 - The person is performing as a pilot or a crew member of any aircraft
 - You are riding as a passenger in an aircraft owned, operated, controlled, or leased by Microsoft, its subsidiaries, or affiliates. This includes getting in, out, on, or off any such vehicles.
- Commission of or attempt to commit a felony
- While operating an air, land, or water vehicle, being legally intoxicated or under the influence of any narcotic unless administered or consumed on the advice of a doctor

Section X: Long-term disability

(LTD)

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How the plan works

The long-term disability (LTD) plan is designed to provide income replacement in the event you experience a prolonged injury or illness. The LTD plan also offers additional benefits to support you and your family. The plan is administered by Prudential.

You can choose one of three coverage levels, as shown in the table below. If you don't elect coverage, your coverage level will default to 60% coverage.

Election	Coverage
40% Coverage	Covers 40% of your monthly earnings, up to a maximum of \$10,000 per month
50% Coverage	Covers 50% of your monthly earnings, up to a maximum of \$12,500 per month
60% Coverage (default if no coverage elected)	Covers 60% of your monthly earnings, up to a maximum of \$15,000 per month



Monthly earnings are your gross monthly income just prior your date of disability. For a complete definition, please review the [glossary](#).

Regardless of which coverage level you choose, Microsoft pays the full cost of your LTD coverage. The monthly premium amount of this coverage is considered taxable income to you. You do not pay taxes on Microsoft's contribution to your coverage while you are receiving monthly payments.

If you become disabled while covered by this plan, you may receive a monthly payment and other LTD benefits after an elimination period and provided you meet certain eligibility criteria. Your monthly payments may be reduced by other sources of income or if you continue working while you are disabled. Prudential will send you a payment each month up to a maximum period.

All LTD benefits are subject to the plan's [Exclusions and limitations](#). Each benefit may have additional eligibility criteria and exclusions and limitations. More information on what is covered is provided on the following pages.



For more information about conditions of coverage and payable benefits, see the [Long-term Disability Insurance Certificate](#).



All benefits and coverages described in this plan description are subject to the terms of the insurance policies under which the benefits are provided. If there is any conflict between this summary and the insurance policies, the insurance policies will always govern.

When LTD benefits begin

Following an elimination period, you will be eligible for monthly payments and other LTD benefits if you meet the criteria described below.

Elimination period

The elimination period is 26 weeks, beginning from your injury or onset of your illness. You can satisfy your elimination period while working, provided you meet Prudential's definition of disability including the additional criteria for [eligibility while working](#) described below.



Short-term disability (STD) provides up to 26 weeks of leave for a non-work-related illness or injury. For information about STD leave, visit the [Leave of Absence \(LOA\) tool](#).

You may have one or more periods of recovery during the elimination period without having to restart the elimination period if both of the following occur:

- You become disabled again from the same or a related medical condition
- You complete the 182-day elimination period within one year (365 days) from the date the disability commenced

If you do not satisfy the elimination period within 365 days, any new period of disability from the same or a related medical condition will be treated as a new claim.

Eligibility criteria

You are considered eligible for monthly payments when Prudential determines that, due to your illness or injury, you are:

- Unable to perform the material and substantial duties of your regular occupation, or you have a 20% or more loss in your monthly earnings; and
- Under the regular care of a doctor



Material and substantial duties are those duties normally required as part of your job that cannot be reasonably omitted or modified. If you are required to work on average more than 40 hours per week, you are considered able to meet this duty if you are able to work 40 hours per week.

Regular care of a doctor means you visit a doctor as frequently as is medically required to manage and treat your condition. For a complete definition, please review the [glossary](#).

Example

Caitlin earned \$6,000 a month before her disability and continued to work part-time after her disability, earning less than \$4,800 a month. She would be eligible for partial monthly payments as long as she can no longer perform the material and substantial duties of her job and she is under a doctor's care.

Your LTD benefits will continue after 24 months if Prudential determines that, due to the same illness or injury, you are:

- Unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training, or experience that provides income exceeding your monthly payment, if you are not working; or exceeding 80% of your indexed monthly earnings, if you are working, and
- Under the regular care of a doctor



Your **indexed monthly earnings** are your monthly earnings, adjusted by the lesser of 10% or the current annual percentage increase in the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W). Adjustments are made on each July 1, provided you were disabled for all of the 12 months before that date. Your indexed monthly earnings may increase or remain the same, but will never decrease.

Example

After two years, Caitlin's indexed monthly earnings are \$7,260. If Caitlin is working, she will continue to receive partial monthly payments if that income is lower than \$5,808 (80% of \$7,260) and she is unable to perform any occupation that provides a greater income and she is under a doctor's care.



The loss of a professional or occupational license or certification does not, in itself, constitute disability.

Prudential will assess your ability to work and the extent to which you are able to work by considering the facts and opinions from your doctors. Prudential may require you to be examined as often as it is reasonable by doctors, other medical practitioners, or vocational experts of Prudential's choosing. Prudential will pay for these exams. Prudential may require you to be interviewed by an authorized Prudential representative. Refusal to be examined or interviewed may result in denial or termination of your claim.



*If you are unable to perform at least two daily activities without substantial assistance or have severe cognitive impairment, you may be eligible for additional monthly payments under the **catastrophic disability** benefit.*

If you are working while disabled

In certain situations, you may be able to work in a different job than you had when you became disabled. If you meet the above criteria and are working, you are eligible for monthly payments. However, your monthly payments may be reduced if your income from working while disabled exceeds 20% of your indexed monthly earnings. If you become covered under any other LTD plan while working, you won't be eligible for payments under this LTD plan.



You must notify Prudential immediately when you return to work in any capacity.

If you get better within 30 days

If, after satisfying the elimination period, you are disabled for less than one month, Prudential will send you 1/30 of your payment for each day of disability.

Example

If you recover from your disability 15 days after of satisfying the elimination period, your monthly payment will be reduced by half to cover the number of days you were disabled.

If your disability recurs

If you return to work full time after receiving monthly payments and your disability occurs again, Prudential will treat your disability as part of your prior claim and you will not have to complete another elimination period if both of the following is true:

- You were continuously insured under this plan for the period between your prior claim and your current disability
- Your recurrent disability occurs within six months of the end of your prior claim
- Your recurrent disability will be subject to the same terms of the plan as your prior claim. Any disability which occurs after six months from the date your prior claim ended will be treated as a new claim.



A **recurrent disability** is an injury or illness that worsens and is due to one or more of the same causes as a prior disability for which Prudential made a monthly payment.

What the plan pays

Your monthly payments are calculated using your monthly income as of your earnings calculation date, which is the latest of:

- The date you meet the eligibility requirements above
- The date you commence an approved disability leave of absence or workers' compensation leave of absence
- The date immediately preceding the beginning of your elimination period if you have to restart your elimination period
- Your last full day of employment if you become disabled while you are on a covered layoff or an approved leave of absence

Monthly payments may be reduced if:

- You have deductible sources of income, such as workers' compensation payments or disability income payments from Social Security or another retirement plan. For a complete list, please review [deductible sources of income](#) later in this section.
- You have disability earnings, which are any income you receive while working and any additional income you could receive if you work to your greatest extent possible, as follows:
 - For the first 24 months, your disability earnings are from your regular occupation.
 - After 24 months, disability earnings are from any available occupation for which you are reasonably fitted by education, training or experience.



If your disability earnings exceed 80% of your indexed monthly earnings (your income prior to disability, adjusted for inflation), Prudential will stop sending you payments and your claim will end. If your disability earnings fluctuate, your indexed monthly earnings will be averaged over a period of 3 months to determine continued eligibility for payment.

For the first twelve months of your disability, your monthly payment is calculated as follows:

Step	Calculation	Example
1	Determine your gross monthly payment, which is the lesser of the following: <ul style="list-style-type: none"> Your coverage level multiplied by your monthly income just prior to your earnings calculation date The maximum monthly payment for your coverage level 	Emrah earned \$7,000 a month before his disability and he elected the 60% coverage level. <ul style="list-style-type: none"> $\\$7,000 \times 60\% = \\$4,200$ Since \$4,200 is less than the maximum monthly payment of \$15,000, his gross monthly payment is \$4,200.
2	Subtract any deductible sources of income from your gross monthly payment to calculate your monthly payment.	Emrah has no deductible sources of income, so his monthly payment is \$4,200.
3	If your disability earnings are more than 20% of your monthly earnings, your monthly payment will be reduced as follows: <ul style="list-style-type: none"> Add your gross monthly payment and your return to work earnings Subtract your indexed monthly earnings from the result, if you are disabled and working If the result is a positive number, you will continue to receive the full monthly payment If the result is a negative number, that amount will be subtracted from your monthly payment 	Emrah's return to work earnings are \$3,000. He's also working while disabled. <ul style="list-style-type: none"> Adding his gross monthly payment and his monthly return to work earnings, he gets \$7,200 ($\\$4,200 + \\$3,000$) Subtracting this amount (\$7,200) from his indexed monthly earnings (\$7,000) results in a negative number ($-\\$200$) Emrah's adjusted monthly payment is \$4,000 ($\\$4,200 - \\$200$). <p>If Emrah works to his full potential and earns \$3,000, his total income would be \$7,000.</p>



The minimum monthly payment is 10% of the gross monthly payment or \$100, whichever is less. If your benefit is subject to offset(s) resulting in a minimum monthly payment while working, you may be eligible to receive a partial minimum monthly payment.

After 12 months, the disability earnings adjustment to your monthly payment will be calculated as follows:

Step	Calculation
1	Calculate your lost earnings by subtracting your disability earnings from your indexed monthly earnings. <div> <div>Indexed monthly earnings</div> <div>–</div> <div>Disability earnings</div> <div>=</div> <div>Lost earnings</div> </div> <div> <div>Your income prior to your disability, adjusted for inflation</div> <div></div> <div>Your actual and potential income from working with a disability</div> </div>
2	Calculate your percentage of lost earnings by dividing the result by your indexed monthly earnings <div> <div>Lost earnings</div> <div>/</div> <div>Indexed monthly earnings</div> <div>=</div> <div>Percentage of lost earnings</div> </div> <div> <div>Income lost due to disability</div> <div></div> <div>Your income prior to disability, adjusted for inflation</div> </div>

3	Multiply the result by your unadjusted monthly payment.				
	Monthly payment	X	Percentage of lost earnings	=	Monthly payment after 12 months
	Gross monthly payment, adjusted for deductible sources of income		Percentage of income lost due to disability		

Example

After a year, Emrah's indexed monthly earnings go up to \$7,700. His monthly payment would be calculated as follows:

- Subtracting his disability earnings from his indexed monthly earnings, we get lost earnings of \$4,700 (\$7,700-\$3,000).
- Dividing his lost earnings by his indexed monthly earnings, we get a percentage of lost earnings of 61% (\$4,700/\$7,700).
- Multiplying this by the monthly payment he would receive if he were not working, we get a monthly payment of \$2,562 (61% x \$4,200)

Emrah's total income from employment and his monthly payment would be \$5,562.

Proof of income

Prudential may require you to send proof of your income from employment while receiving monthly payments, including copies of your IRS federal income tax return, W-2 and 1099 forms.

Income fluctuation

If your income from employment while receiving monthly payments is expected to fluctuate widely from month to month, Prudential may average your disability earnings over the most recent three months to determine if your claim should continue subject to all other terms and conditions in the plan. In this situation, Prudential will terminate your claim if the average of your disability earnings from the last three months exceeds 80% of indexed monthly earnings. Prudential will not pay you for any month during which disability earnings exceed the above amounts.

Deductible sources of income

Prudential will deduct the following sources of income from your gross LTD amount to calculate your monthly payment:

Deductible sources of income	
1	<p>The amount you receive or are entitled to receive as loss-of-time benefits under:</p> <ul style="list-style-type: none"> • A workers' compensation law • An occupational disease law • Any other act or law with similar intent
2	<p>The amount you receive or are entitled to receive as loss-of-time disability income payments under any:</p> <ul style="list-style-type: none"> • State compulsory benefit act or law • Automobile liability insurance policy required by law • Insurance or a health or welfare plan or other group insurance plan where Microsoft, directly or indirectly, has paid all or part of the cost or has made payroll deductions • Governmental retirement system as the result of your job with Microsoft

Deductible sources of income	
3	<p>The gross amount that you, your spouse and children receive or are entitled to receive as loss-of-time disability payments because of your disability under:</p> <ul style="list-style-type: none"> • The United States Social Security Act • The Railroad Retirement Act • The Canada Pension Plan • The Quebec Pension Plan • Any similar plan or act <p>Amounts paid to your former spouse or to your children living with such spouse will not be included.</p>
4	<p>The gross amount that you receive as retirement payments or the gross amount your spouse and children receive as retirement payments because you are receiving payments under:</p> <ul style="list-style-type: none"> • The United States Social Security Act • The Railroad Retirement Act • The Canada Pension Plan • The Quebec Pension Plan • Any similar plan or act <p>Benefits paid to your former spouse or to your children living with such spouse will not be included.</p>
5	<p>The amount that you:</p> <ul style="list-style-type: none"> • Receive as disability payments under the Microsoft retirement plan, if any • Voluntarily elect to receive as retirement or early retirement payments under the Microsoft retirement plan • Receive as retirement payments when you reach normal retirement age, as defined in the Microsoft retirement plan. Disability payments under a retirement plan will be those benefits that are paid due to disability and do not reduce the retirement benefits that would have been paid if the disability had not occurred. Retirement payments will be those benefits that are paid based on the amount that Microsoft contributes to the retirement plan. Disability benefits which reduce the retirement benefits under the Plan will also be considered as a retirement benefit. Amounts received do not include amounts rolled over or transferred to any eligible retirement plan. Prudential will use the definition of eligible retirement plan as defined in Section 402 of the Internal Revenue Code, including any future amendments which affect the definition.
6	<p>The amount you receive under the maritime doctrine of maintenance, wages and cure. This includes only the wages part of such benefits.</p>
7	<p>The amount of loss-of-time benefits that you receive or are entitled to receive under any salary continuation or accumulated sick leave that exceed or would exceed 100 % of your monthly earnings. Salary continuation and accumulated sick leave include continued payments to you by Microsoft of all or part of your monthly earnings, after you become disabled. This continued payment must be part of an established plan maintained by Microsoft for the benefit of an employee. Salary continuation or accumulated sick leave does not include compensation paid to you by Microsoft for work you actually perform after your disability begins.</p>
8	<p>The amount that you receive from a partnership, proprietorship, or any similar draws.</p>
9	<p>The amount that you receive or are entitled to receive under any unemployment income act or law due to the end of employment with Microsoft.</p>

With the exception of retirement payments or amounts that you receive from a partnership, proprietorship, or any similar draws, Prudential will subtract only deductible sources of income which are payable as a result of the same disability.

Prudential will not reduce your payment by your Social Security retirement payments if your disability begins after age 65 and you were already receiving Social Security retirement payments.

If Prudential determines you qualify for benefits under item one, two, or three

If Prudential determines that you may qualify for benefits under item one, two, or three in the list of deductible sources of income above, Prudential will estimate your entitlement to these benefits. Prudential can reduce your payment by the estimated amount even if such benefits have not been awarded. However, Prudential will not reduce your payment if you do all of the following:

- Apply for the benefits
- Appeal any denial to all administrative levels that Prudential feels are necessary
- Sign Prudential's Reimbursement Agreement form. This form states that you promise to pay Prudential any overpayment caused by an award.



If your payment has been reduced by an estimated amount, your payment will be adjusted when Prudential receives proof of one of the following:

- *The amount awarded*
- *That benefits have been denied and all appeals that Prudential feels are necessary have been completed*

In this case, a lump sum refund of the estimated amount will be made to you.

If Prudential determines you qualify for benefits under item seven or nine

If Prudential determines that you may qualify for benefits under item seven or nine in the list of deductible sources of income above, Prudential will estimate your entitlement to these benefits. Prudential can reduce your payment by the estimated amount if such benefits have not been received.



If you receive a lump sum payment from any deductible source of income, the lump sum will be prorated on a monthly basis over the time period for which the sum was given. If no time period is stated, Prudential will use a reasonable one.

Minimum monthly payment

If subtracting deductible sources of income results in a zero benefit, the minimum monthly payment is the greater of (a) 10% of the gross disability payment otherwise payable, and (b) \$100. Prudential may apply this amount toward an outstanding overpayment.

After Prudential has subtracted any deductible source of income from your gross disability payment, Prudential will not further reduce your payment due to a cost-of-living increase from that source.

Non-deductible sources of income

Prudential will not deduct from your gross disability payment income you receive from, but not limited to, the following sources:

- 401(k) plans
- Profit sharing plans
- Thrift plans
- Tax-sheltered annuities
- Stock ownership plans
- Non-qualified plans of deferred compensation
- Pension plans for partners

- Military pension and disability income plans
- Credit disability insurance
- Franchise disability income plans
- A retirement plan from another employer
- Individual Retirement Accounts (IRAs)

When monthly payments stop

Prudential will stop monthly payments while you are incarcerated as a result of a conviction.

Prudential will stop payments and your claim will end on the earliest of the following:

- During the first 24 months of payments, when you are able to work in your regular occupation on a part-time basis and earn 20% or more of your indexed monthly earnings but you choose not to
- After 24 months of payments, when you are able to work in any gainful occupation on a part-time basis and earn 20% or more of your indexed monthly earnings but you choose not to
- The end of the maximum period of payment as described below
- The date you are no longer disabled under the terms of the plan
- The date you fail to submit proof of continuing disability satisfactory to Prudential
- The date your disability earnings exceed the amount allowable under the plan
- The date you decline to participate in a rehabilitation program that Prudential considers appropriate for your situation and that is approved by an independent doctor
- The date you die

Maximum period of payment

Prudential will provide you a monthly payment each month up to the maximum period of payment as shown in the table below:

Your age on date of disability begins	Your maximum period of benefits
Under age 61	To your normal retirement age*, but not less than 60 months
Age 61	To your normal retirement age*, but not less than 48 months
Age 62	To your normal retirement age*, but not less than 42 months
Age 63	To your normal retirement age*, but not less than 36 months
Age 64	To your normal retirement age*, but not less than 30 months
Age 65	24 months
Age 66	21 months
Age 67	18 months
Age 68	15 months
Age 69 and over	12 months

* Your normal retirement age is your retirement age under the Social Security Act, where retirement age depends on your year of birth.

The LTD plan limits the maximum pay period to a combined 24 months during your lifetime for the following disabilities:

- Disabilities based on self-reported symptoms, determined by Prudential as manifestations of your condition that are not verifiable using tests, procedures, and clinical examinations standardly accepted in the practice of medicine. Examples of self-reported symptoms include, but are not limited to: headache, pain, fatigue, stiffness, soreness, ringing in ears, dizziness, numbness, and loss of energy.
- Disabilities due in whole or part to mental illness, determined by Prudential as a psychiatric or psychological condition regardless of cause. Mental illness includes but is not limited to schizophrenia, depression, manic depressive or bipolar illness, anxiety, somatization, substance-related disorders, and/or adjustment disorders or other conditions. These conditions are usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment as standardly accepted in the practice of medicine.

The limitation of 24 months for mental illness does not apply if you meet one of the following conditions:

- If you are confined to a hospital or institution for at least eight hours a day at the end of the 24-month period. If you are still disabled when you are discharged, Prudential will send you payments for a recovery period of up to 90 days. If you become reconfined for at least eight hours a day at any time during the recovery period and remain confined for at least 14 days in a row, Prudential will send payments during that additional confinement and for one additional recovery period up to 90 more days.
- If, after the 24-month period, you continue to be disabled and subsequently become confined for at least eight hours a day to a hospital or institution for at least 14 days in a row, Prudential will send payments during the length of the confinement.
- If you have dementia as a result of the following:
 - Stroke
 - Trauma
 - Viral infection
 - Alzheimer's disease
- Other conditions which are not usually treated by a mental health provider or other qualified provider using psychotherapy, psychotropic drugs, or other similar methods of treatment as standardly accepted in the practice of medicine



Prudential will not pay beyond the limited pay period as indicated above, or the maximum period of payment, whichever occurs first.

Other benefits

In addition to the monthly payments, this plan provides the following benefits in the event of your disability.

Survivor benefit

If you should die within 365 days of your disability and are receiving monthly payments from this plan at the time of your death, Prudential will pay a benefit equal to six months of your gross monthly payment to your eligible survivors, which include your spouse/domestic partner, if living; otherwise, your children under age 25. Your survivor will need to provide proof of your death.

If a benefit is payable to a minor or a person incapable of receiving payment, Prudential may pay the amount to any person or institution that appears to have assumed custody and main support of that person. If you have no eligible survivors, payment will be made to your estate.

Survivor benefit prior to death

If you are receiving monthly payments and you become terminally ill, you may elect to receive the survivor benefit prior to your death. Prudential will pay the survivor benefit if:

- You elect this option in writing in a form that satisfies Prudential
- You provide proof that you are a terminally ill employee, including certification by your doctor that your life expectancy is six months or less
- Your long-term disability coverage is not assigned
- You elect this benefit only on a voluntary basis



You are not eligible for this benefit if:

- *You are required by law to use this benefit to meet the claims of creditors, whether in bankruptcy or otherwise*
- *You are required by a government agency to use this benefit in order to apply for, get, or keep a government benefit or entitlement*

You may elect the survivor benefit prior to death option only once during your lifetime. If you elect to receive this benefit prior to your death, no survivor benefit will be paid upon your death. However, Prudential will first apply the survivor benefit to any overpayment which may exist on your claim.

Catastrophic disability

You are catastrophically disabled when Prudential determines that, due to the same sickness or injury that caused your disability, one of the following is true:

- You are unable to perform, without substantial assistance, at least two activities of daily living, including:
 - Bathing—Washing oneself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower
 - Continence—The ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel and bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag)

- Dressing—Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs
- Eating—Feeding oneself from a plate, cup or table or by feeding tube or intravenously
- Toileting—Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene
- Transferring—Sufficient mobility to move into or out of a bed, chair, or wheelchair or to move from place to place, either by walking, using a wheelchair, or by other means
- You have a severe cognitive impairment, which requires substantial supervision to protect you from threats to health and safety



Substantial assistance includes:

- The physical assistance of another person without which the family member would not be able to perform an activity of daily living
- The constant presence of another person within arm's reach who is necessary to prevent, by physical intervention, injury to the family member while the family member is performing an activity of daily living

Cognitive impairment is a loss or deterioration in intellectual capacity that is comparable to and includes Alzheimer's disease and similar forms of irreversible dementia. For a complete definition, please review the [glossary](#).

Substantial supervision means continual oversight that may include cueing by verbal prompting, gestures, or other demonstrations by another person, and which is necessary to protect you or the family from threats to your or the family member's health or safety.

You will receive catastrophic disability payments when Prudential approves your claim, providing:

- You are receiving monthly payments under the plan
- You have had your catastrophic disability for a period of at least 30 consecutive days

Your monthly catastrophic disability payment, which is an additional benefit on top of the regular monthly payment, is equal to 20% of your monthly earnings, but not more than \$5,000. It will not be reduced by any deductible sources of income.

You will stop receiving payments and your catastrophic disability claim will end on the earliest of the following:

- The date you no longer have a catastrophic disability under the terms of the plan
- The date you fail to submit proof of continuing catastrophic disability satisfactory to Prudential
- The date you are no longer receiving monthly payments under the plan

Worksite modification

A worksite modification might allow you to perform the material and substantial duties of your regular job. One of Prudential's designated professionals will work with you to identify a modification to help you remain at work or return to work. This modification must be documented in writing and signed by you, Microsoft, and Prudential. This modification benefit is available to you one time only.

Prudential will reimburse Microsoft for the cost of the modification up to the greater of:

- \$1,000
- The equivalent of two months of your gross monthly payment

Social Security advice

Prudential can arrange for expert advice regarding your Social Security disability benefits claim and assist you with your application or appeal, if you are disabled under the plan. Receiving Social Security disability benefits may enable the following:

- You to receive Medicare after 24 months of disability payments
- You to protect your retirement benefits
- Your family to be eligible for Social Security benefits

Prudential can assist you in obtaining Social Security disability benefits by:

- Helping you find appropriate legal representation
- Obtaining medical and vocational evidence
- Reimbursing pre-approved case management expenses



If you are enrolled for life insurance when you become disabled, you may be eligible for a waiver of your life insurance premiums. For more information, see the [Employee and Dependent life insurance](#) section.

Continuing health care coverage

Prudential will send you a payment each month for continued health care coverage costs up to the maximum period of continued health care payments while:

- You are receiving long-term disability benefits under the plan
- You are continuing your health care coverage under COBRA or similar state law
- Prudential has written proof of the cost to you of this coverage

The maximum period of continued health care payments is 29 months. Continued health care payments will end on the earliest of the following:

- The end of the maximum period of continued health care payments
- The date you return to work or become eligible for group health insurance
- The date you are enrolled in Medicare
- The date you no longer receive long term-disability benefits under the Plan
- The date you fail to provide proof of COBRA continuation

The monthly continued health care payment is \$500. But your monthly continued health care payment will not exceed the actual costs to you for continued health care coverage.



Continued health care coverage costs means the actual costs to you for continued health care coverage provided through your employer, and which you elect under COBRA or similar state law.

Rehabilitation services

Prudential may review your file to determine if rehabilitation services might help you return to work. Once the review is completed by our rehabilitation specialists, working along with your doctor and other appropriate specialists, Prudential may pay for a rehabilitation program. If the program is not developed by Prudential's rehabilitation specialists, you must receive written approval from Prudential before beginning the program.

The rehabilitation program may include, but is not limited to:

- Coordination with Microsoft to assist you to return to work
- Evaluation of adaptive equipment to allow you to work
- Vocational evaluation to determine how your disability may impact your employment options
- Job placement services
- Resume preparation
- Job seeking skills training
- Retraining for a new occupation
- Assistance with relocation that may be part of an approved rehabilitation program

If, at any time, you decline to take part in or cooperate in a rehabilitation evaluation/assessment or program that Prudential feels is appropriate for your disability and that has been approved by your doctor, Prudential will cease your monthly payment.

Prudential will send you a rehabilitation payment each month up to the maximum period of rehabilitation payment while you are doing all of the following:

- Receiving LTD payments under the plan
- Participating in a rehabilitation program that has been approved by Prudential

Your maximum period of rehabilitation payment is six months. The monthly rehabilitation payment is equal to 10% of your monthly LTD payment. But the monthly rehabilitation payment, together with your monthly LTD payment, will not exceed the maximum monthly LTD payment.

Childcare

Prudential will send you a monthly childcare payment for up to six months while you are doing all of the following:

- Receiving LTD payments under the plan
- Participating in a rehabilitation program that has been approved by Prudential

The monthly daycare payment is equal to the amount of your eligible daycare expenses up to the maximum monthly daycare amount of \$500 multiplied by the number of eligible children, which are children age 12 or under who live with you, including your legally adopted children, your stepchildren and foster children.

Eligible daycare expenses are:

- Charged by a childcare provider who is not a member of your immediate family (you, your spouse/domestic partner, or a child, brother, sister, or parent of you or your spouse/domestic partner)
- Documented by receipts from the childcare provider that include the childcare provider's Social Security number or taxpayer identification number
- Specified in the Prudential-approved rehabilitation program as needed in order for you to participate in the program

Spouse/domestic partner and elder care

Prudential will send you a monthly payment for up to six months while you are doing all of the following:

- Receiving LTD payments under the plan
- Participating in a rehabilitation program that has been approved by Prudential
- The monthly spouse/domestic partner and elder care payment is equal to the amount of your eligible spouse/domestic partner and elder care expenses up to the maximum monthly spouse/domestic partner and elder care amount of \$500 multiplied by the number of eligible family members, which include family members who have a chronic illness or disability, including your spouse/domestic partner, parents, your grandparents who live with you, and your spouse/domestic partner's parents and grandparents who live with you.

Eligible spouse/domestic partner and elder care expenses are:

- Charged by a licensed adult care provider who is not a member of your immediate family (you, your spouse/domestic partner, or a child, brother, sister or parent of you or your spouse/domestic partner)
- Documented by receipts from the licensed adult care provider that include the provider's Social Security number or taxpayer identification number
- Specified in the Prudential-approved rehabilitation program as needed in order for you to participate in the program



A **chronic illness** is one of the following:

- A loss of the ability to perform, without substantial assistance, at least two activities of daily living for a period of at least 30 consecutive days.
 - A severe cognitive impairment, which requires substantial supervision to protect the family member from threats to health and safety, for a period of at least 30 consecutive days.
-



There are state-specific requirements that may change the provisions under the Coverage(s) described in the Group Insurance Certificate. If you live in a state that has such requirements, those requirements will apply to your Coverage(s) and are made a part of your Group Insurance Certificate.

Prudential has a website that describes these state-specific requirements. You may access the website at www.prudential.com/etonline. When you access the website, you will be asked to enter your state of residence and your Access Code. Your Access Code is 43994.

Exclusions and limitations

The plan does not cover any disabilities caused by, contributed to by, or resulting from the following:

- Intentionally self-inflicted injuries
- Active participation in a riot
- Commission of a crime for which you have been convicted under state or federal law
- The plan does not cover a disability due to a preexisting condition
- The plan does not cover a disability due to war, declared or undeclared, or any act of war



Prudential considers you to have a **preexisting condition** if both are true:

- You received medical treatment, consultation, care or services, including diagnostic measures, or took prescribed drugs or medicines, or followed treatment recommendation in the three months prior to your effective date of coverage or the date an increase in benefits would be available
- Your date of disability begins within 12 months of the date your coverage under the plan becomes effective

You do not have a preexisting condition if, after the date your coverage under the plan becomes effective or the date an increase in benefits would otherwise be available, there is a period of six months or more during which you do not receive the care described above.

How to file a claim

Be sure to notify Prudential of your claim as soon as possible. Written notice of a claim should be sent within 30 days after the date your disability begins. However, you must send Prudential written proof of your claim no later than 90 days after your elimination period ends. If it is not possible to give proof within 90 days, it must be given no later than one year after the time proof is otherwise required, except in the absence of legal capacity.



Absence of legal capacity means an individual is no longer able to act on his or her own behalf. Ultimately, the individual is not able to execute legal documents.



The claim forms are available from Benefits, or you can e-mail or call Prudential at (800) 842-1718 to request a claim form. If you do not receive a form from Prudential within 15 days of your request, you can send Prudential a written proof of claim without the form to:

Disability Management Services
P.O. Box 13480
Philadelphia, PA 19101

You and Microsoft must fill out your respective section of the claim form and then give it to your attending doctor. Your doctor should fill out his or her section of the form and send it directly to Prudential.

Your proof of claim, provided at your expense, must show the following:

- That you are under the regular care of a doctor
- The appropriate documentation of your monthly earnings
- The date your disability began
- Appropriate documentation of the disabling disorder
- The extent of your disability, including restrictions and limitations preventing you from performing your regular occupation or any gainful occupation or an activity of daily living
- The name and address of any hospital or institution where you received treatment, including all attending doctors
- The name and address of any doctor you have seen

Proof of continuing disability

Prudential may request that you send proof of continuing disability, satisfactory to Prudential, indicating that you are under the regular care of a doctor. In some cases, you will be required to give Prudential authorization to obtain additional medical information, and to provide non-medical information (for example, copies of your IRS federal income tax return, W-2 forms and 1099 forms) as part of your proof of claim, or proof of continuing disability. This proof, provided at your expense, must be received within 30 days of a request by Prudential. Prudential will deny your claim or stop sending you payments if the appropriate information is not submitted.



Prudential will not recognize any relative including, but not limited to, you, your spouse/domestic partner, or a child, brother, sister, or parent of you or your spouse/domestic partner as a doctor for a claim that you send to us.

Payments

Prudential will make payments to you. Prudential has the right to recover any overpayments due to the following:

- Fraud
- Any error Prudential makes in processing a claim
- Your receipt of deductible sources of income

You must reimburse Prudential in full. Prudential will determine the method by which the repayment is to be made. Prudential will not recover more money than the amount Prudential paid you.



If you knowingly and with intent defraud Prudential, file an application or a statement of claim containing any materially false information or conceal, for the purpose of misleading, information concerning any fact material thereto, you commit a fraudulent insurance act, which is a crime and subjects you to criminal and civil penalties. These actions will result in denial or termination of your claim, and, where such laws apply, are subject to prosecution and punishment to the full extent under any applicable law. Prudential will pursue all appropriate legal remedies in the event of insurance fraud.

Determination of Benefits

Prudential will let you know within 45 days of the receipt of your claim if your claim is accepted or denied. This period may be extended by 30 days due to matters beyond the control of the plan. A written notice of the extension, the reason for the extension, and the date by which the plan expects to decide your claim, will be sent to you within the initial 45-day period. This period may be extended for an additional 30 days. You will be sent a written notice of the additional extension within the first 30 days of the extension period.

However, if time is extended due to your failure to submit information necessary to decide the claim, the period for making the benefit determination will be counted from the date on which the notification of the extension is sent to you until the date on which you respond to the request for additional information.

If your claim for benefits is denied

If your claim for benefits is denied, in whole or in part, you or your authorized representative will receive a written notice from Prudential of your denial. The notice will include:

- One or more specific reasons for the denial
- References to the specific plan provisions on which the benefit determination was based
- A description of any additional material or information necessary for you to perfect a claim and an explanation of why such information is necessary
- A description of Prudential's appeals procedures and applicable time limits, including a statement of your right to bring a civil action under section 502(a) of ERISA following your appeals
- If an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon request

Appeals

If your claim for benefits is denied or if you do not receive a response to your claim within the appropriate timeframe (in which case the claim for benefits is deemed to have been denied), you or your representative may appeal your claim in writing to Prudential within 180 days of the receipt of the written notice of denial or 180 days from the date such claim is deemed denied.

You may submit with your appeal, any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

A full review of the information in the claim file and any new information submitted to support the appeal will be conducted by individuals not involved in the initial benefit determination. Prudential shall make a determination on your claim appeal within 45 days of the receipt of your request. This time may be extended by additional 45 days if Prudential determines that special circumstances require an extension. Within the initial 45-day period, you will receive a written notice of the extension, the reason for the extension and the date that Prudential expects to render a decision.

However, if the time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be counted from the date the notice of the extension is sent to you until the date on which you respond to the request for additional information.

If your appeal for benefits is denied

If the claim on appeal is denied in whole or in part, you will receive a written notice from Prudential. The notice shall include:

- One or more specific reasons for the adverse determination
- References to the specific plan provisions on which the determination was based
- A statement that you are entitled to receive upon request and free of charge reasonable access to, and make copies of, all records, documents and other information relevant to your benefit claim upon request
- A description of Prudential's review procedures and applicable time limits
- A statement that you have the right to obtain upon request and free of charge, a copy of internal rules or guidelines relied upon in making this determination
- A statement describing any appeals procedures offered by the plan, and your right to bring a civil suit under ERISA

Submitting a second appeal

If the appeal of your benefit claim is denied or if you do not receive a response to your appeal within the appropriate timeframe (in which case the appeal is deemed to have been denied), you or your representative may make a second, voluntary appeal in writing to Prudential within 180 days of the receipt of the written notice of denial, or 180 days from the date your claim is denied. You may submit with your second appeal, any written comments, documents, records and any other information relating to your claim. Upon your request, you will also have access to, and the right to obtain copies of, all documents, records and information relevant to your claim free of charge.

Prudential shall make a decision on your second claim appeal within 45 days of the receipt of your request. This period may be extended by up to an additional 45 days if Prudential determines that special circumstances require it. Within the initial 45-day period, you will receive a written notice of the extension, the reason for the extension and the date by which Prudential expects to render a decision. However, if the time is extended due to your failure to submit information necessary to decide the appeal, the period for making the benefit determination will be counted from the date the notice of the extension is sent to you until the date on which you respond to the request for additional information.

Submitting a benefit dispute

Your decision to submit a benefit dispute to this voluntary second level of appeal has no effect on your right to any other benefits under this plan. If you elect to initiate a lawsuit without submitting to a second level of appeal, the plan waives any right to assert that you failed to exhaust administrative remedies. If you elect to submit the dispute to the second level of appeal, the plan agrees that any statute of limitations or other defense based on timeliness is counted during the time that the appeal is pending.

If the claim on appeal is denied in whole or in part for a second time, you will receive a notice from Prudential. The notice shall include the same information that was included in the first adverse determination letter. If a decision on appeal is not furnished to you within the timeframes mentioned above, the claim shall be deemed denied on appeal. When the appeals process has been exhausted, you can start legal action regarding your claim 60 days after proof of claim has been given and up to three years from the time proof of claim is required, unless otherwise provided under federal law.

Section XI: Group legal plan

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How the plan works

The Group Legal Insurance Plan from ARAG® offers assistance with many routine legal services for you, your spouse/domestic partner, and eligible dependents. The plan pays 100% of attorneys' fees for most covered services. Any interactions you have with your attorney are confidential. Microsoft will have access only to the enrollment information needed to administer your coverage.

If you select this optional coverage, you will pay the monthly premiums with after-tax dollars. The cost of coverage is available in the [Benefits Enrollment tool](#). Once you elect to participate, you may not cancel this coverage except during the annual open enrollment period.



If you have been enrolled in the plan for at least one year and you leave Microsoft, you may convert your coverage to an individual plan through ARAG. For more information, visit the [Coverage if you leave Microsoft](#) section.



To review your Certificate of Insurance, find a network attorney, or get more information about the benefits under this plan, call ARAG at (800) 331-3425, e-mail Service@ARAGgroup.com, or log onto the Benefits site and visit the [ARAG Legal Center](#).

Where you can get legal help

The legal plan covers services from any attorney. You can also get help by phone and online from ARAG.

Although you can receive services from any licensed attorney, you pay less when you use an ARAG Network Attorney.

- If you use a Network Attorney, the plan pays 100% of the attorney's fee for most covered services. In addition, you can save money even if your legal situation is not fully covered by using Network Attorneys, as they provide reduced fees of at least 25% off their normal rate for any legal situations that are not excluded.
- If you use an out-of-network attorney for covered services, the plan will reimburse you based on the fee schedule provided in the [What the plan covers](#) section.



Remember, any interaction you have with your Network Attorney through ARAG is confidential. Microsoft will have access only to basic enrollment information needed to administer your coverage.

Finding an attorney

For a list of Network Attorneys in your area, you can:

- Visit the [ARAG Legal Center](#) to search for attorneys in your area by legal expertise
- Call (800) 331-3425 to contact a Customer Care Specialist, who will provide you with:
 - A list of network attorneys in your area, related to your legal matter, along with their phone numbers and the languages they speak

- CaseAssist Confirmation Form to provide to the Network Attorney of your choice so he/she will have the information needed to begin your case work (i.e., your member ID number, benefit coverage details, contact information)
- Educational information including tips about working with attorneys and a checklist of items to bring in preparation of your first meeting

After you select a Network Attorney from the list, call the attorney directly and tell the attorney's staff that you are a participant in an ARAG legal plan. The attorney's staff will:

- Verify your case confirmation number, or may assist in providing you with one
- Provide legal services
- File a claim on your behalf with ARAG for reimbursement of covered legal services



You do not pay the attorney's fees or file a claim for covered legal services with In-Network Attorneys. You will be responsible for out-of-pocket expenses such as filing fees, court costs, title work, and photocopies.

If you use an out-of-network attorney, you will need to file a claim for reimbursement. Please see the [How to file a claim](#) section for more information.

Advice by phone

You may get advice by phone from an ARAG Telephone Attorney about how the law relates to your legal matter and what actions you can take. The plan also covers follow-up correspondence and telephone calls to third parties on your behalf.



To access legal services by phone, call ARAG at (800) 331-3425.

Document preparation and review

You can receive assistance by phone with the preparation/review of these documents:

- Special Powers of Attorney and revocations
- Childcare authorizations
- Challenge to denial of credit
- Bad check notice
- Promissory note and affidavits related to your personal property
- Bills of Sale related to your personal property
- Standard Will package, including
 - Standard Will documents
 - Testamentary support trusts for children
 - Durable Powers of Attorney/health care powers of attorney and revocations
 - Living wills/advanced health care directives
 - Codicils

The attorney will review any personal legal documents.

Small Claims Assistance

You may receive telephone legal services for your personal small claims matter.

Financial education and counseling

Experienced financial counselors are available over the phone. Counselors are committed to offering you a new level of awareness and confidence to effectively manage your finances on topics such as:

- Financial planning and counseling sessions
- Cash and debt management
- Savings and budgeting
- Federal tax information and education
- Retirement planning and investments, including IRAs and 401(k)s
- Credit Reports
- Mortgage Education

Identity theft protection

Identity Theft Protection and Identity Theft Case Specialists provide you with assistance online and over the phone with the following services:

- Credit monitoring informs you of changes to your credit activity – including loan applications, credit card applications, purchases, etc.
- Internet surveillance monitors thousands of websites and millions of online data points to alert you if your personal information is being traded and/or sold
- Child identity monitoring enables parents or guardians to monitor a minor's online identity and alert them if their personal information is being traded or sold
- Full-service identity restoration with Identity Theft Restoration Specialists who will work on your behalf to restore your identity
- Identity theft insurance provides coverage up to \$1 million for expenses associated with restoring your identity should you become a victim of identity theft
- Lost wallet services with Identity Theft Restoration Specialists to assist you in canceling and reissuing personal documents such as credit cards, driver's license, Social Security Cards, etc.

Immigration assistance

UltimateAdvisor will assist you with the United States immigration process, including:

- Toll-free telephone advice from an attorney on how immigration law relates to your legal matter and what actions may be taken
- Access to immigration education materials
- Access to Network Attorneys who will provide reduced fees of at least 25% off their normal hourly rate for specific covered matters

Online resources

The following resources are available on the ARAG Legal Center:

- How-to Guidebooks and videos that cover timely legal topics such as estate planning, consumer protection and buying or selling a car
- The Law Guide, an online library of helpful articles to help you learn more about common legal matters and become a better informed legal consumer
- DIY Docs[®], which allow you to create your own legal documents

To use this benefit, log on to the [ARAG Legal Center](#). If this is your first visit as a member, you will need to create a new account. Your Member ID number is your Microsoft Employee Identification Number (EIN).

What the plan covers



All benefits are subject to the plan's [Exclusions and limitations](#). Benefits will not be paid for any legal matter that occurs or is initiated before the effective date of your coverage, such as the first event resulting in the need for legal counsel, your first contact with an attorney for your legal matter, or the first court or administrative action regarding your legal matter.

Family law

Category definition	Covered services	Network attorney	Out-of-network attorney (Indemnity benefit)
Adoption proceedings Legal services rendered to the named insured and/or his/her insured spouse in court adoption proceedings to become adoptive parent(s), including advice, office work and court representation	Uncontested proceedings	Paid in full	\$60 per hour, up to \$300
	Contested proceedings	Paid in full	\$1,500 (Includes trial indemnity benefits of \$1,200 for up to three days of trial time)
Divorce or legal separation Legal services rendered to the named insured in a divorce, legal separation and/or annulment of marriage, including advice and negotiation prior to court proceedings	Uncontested proceedings	Paid in full	\$60 per hour, up to \$420
	Contested proceedings	Paid in full	\$1,800 (Includes trial indemnity benefits of \$1,200 for up to three days of trial time)
Estate administration and closing Legal assistance provided to you in administering an insured's bequest that you inherit while your Certificate of Insurance is in effect	Advice, negotiations and office work and/or the applicable property transfers and court appearances	Paid in full	\$60 per hour, up to \$500

Category definition	Covered services	Network attorney	Out-of-network attorney (Indemnity benefit)
Guardianship/conservatorship Legal services rendered to you in court proceedings for appointing a Guardian or Conservator, including advice, office work and court representation	Uncontested proceedings	Paid in full	\$60 per hour, up to \$300
	Contested proceedings	Paid in full	\$1,500 (Includes trial indemnity benefits of \$1,200 for up to three days of trial time)
Name changes Name change proceedings, including initial advice prior to representation		Paid in full	\$60 per hour, up to \$240
Motions to modify <ul style="list-style-type: none"> Legal defense against a motion to modify a final decree regarding alimony, child custody, or child visitation rights Legal defense against the enforcement of a final decree regarding alimony, child custody, or child visitation right Legal dispute about your motion to enforce a final decree regarding child support The exclusion of legal disputes arising out of the inheritance law or involving contracts related to family law matters is waived for this benefit 	Advice, office work and court representation, up to 8 hours per event	Paid in full	\$60 per hour, up to \$420
	Additional hours at ARAG Group contract rate	Billed by network attorney	Not covered
Pre-nuptial agreements Attorney's fees related to preparation of a premarital agreement between you and your prospective spouse		Paid in full	\$60 per hour, up to \$360
Wills, Codicils, and Power of Attorney Individual will or husband and wife will(s) and power of attorney that are prepared at the same time as will(s)	Complex will	Paid in full	\$60 per hour, up to \$300
	Standard will	Paid in full	\$125 individual \$150 husband and wife
	Living will	Paid in full	\$35/individual \$50/spousal documents (2)
	Codicils (an amendment to a will)	Paid in full	\$40/individual \$60/spousal documents (2)
	Durable power of attorneys	Paid in full	\$90

Property law

Category definition	Covered services	Network attorney	Out-of-network attorney (Indemnity benefit)
Bankruptcy Personal non-business bankruptcy or wage-earner plan proceedings	Legal services from initial advice through filing of a Chapter 7 final report or confirmation of a Chapter 13 plan	Paid in full	\$60 per hour, up to \$360
IRS audit protection Attorney's fees related to Internal Revenue Service (IRS) audits for which the initial written notice is first received while your Certificate of Insurance is in effect and relates to your personal income tax return. Appeals to the United States court or a Federal tax court are not covered.	Advice, consultation and negotiation	Paid in full	\$60 per hour, up to \$420
	Representation at IRS audit	Paid in full	\$60 per hour, up to \$900
IRS collection defense Attorney's fees related to legal defense against collection actions after assessment by the Internal Revenue Service (IRS) related to the insured's personal income tax return when the initial written notice of collection for a deficiency or discrepancy is received while your Certificate of Insurance is in effect.	Legal services, including advice, negotiation and office work prior to or without trial representation	Paid in full	\$60 per hour, up to \$1,800
	Court representation at trial as a defendant	Paid in full	\$1,200 (Includes trial indemnity benefits of \$1,200 for up to three days of trial time)
Property protection <ul style="list-style-type: none"> Legal disputes about contracts or obligations for purchase, sale or financing of the named insured's primary residence Legal disputes with neighbors about property rights and property titles related to the named insured's primary residence Legal disputes with your landlord about your rights as tenant of your primary residence, including eviction Legal disputes about contracts or obligations for the transfer of your personal property or legal disputes about your personal property rights 	Legal services, including advice, negotiations and office work prior to or without court representation	Paid in full	\$60 per hour, up to \$240
	Court representation as a plaintiff and/or defendant, including all preparations	Paid in full	\$1,800 (Includes trial indemnity benefits of \$1,200 for up to three days of trial time, \$200 per ½ day for trial time)

Category definition	Covered services	Network attorney	Out-of-network attorney (Indemnity benefit)
Property transfers Services to support the purchase, sale or transfer of property.	<ul style="list-style-type: none"> • Sale of your primary residence: review of documents, preparation of final contract for sale and attendance at closing • Purchase of your primary residence: review of documents, preparation of final contract for purchase and attendance at closing 	Paid in full	\$60 per hour, up to \$360
	Preparation and review of <ul style="list-style-type: none"> • Deeds and mortgages, except those relating to refinancing of real estate property or which are otherwise covered by the legal plan • Promissory notes and affidavits, related to your property, lease contracts (lessee only), consumer credit and/or installment sale contracts 	Paid in full	\$60 per document or contract

Personal and consumer protection

Category definition	Covered services	Network attorney	Out-of-network attorney (Indemnity benefit)
Civil damage claims Legal defense against civil damage(s) claims, except claims involving the ownership or use of a motorized vehicle or claims that are covered by other insurance	Legal services, including advice, negotiation and office work prior to or without court representation	Paid in full	\$60 per hour, up to \$240
	Court representation as a defendant, including all preparations	Paid in full	\$1,800 (Includes trial indemnity benefits of \$1,200 for up to three days of trial time)

Category definition	Covered services	Network attorney	Out-of-network attorney (Indemnity benefit)
Consumer protection Legal disputes about written or implied contracts or obligations for the acquisition, lease, use or financing of goods or services, including debt collection defense	Legal services, including advice, negotiation and office work prior to or without court representation	Paid in full	\$60 per hour, up to \$240
	Court representation as a plaintiff and/or defendant, including all preparations	Paid in full	\$1,800 (Includes trial indemnity benefits of \$1,200 for up to three days of trial time)
Criminal misdemeanor defense Legal defense against criminal misdemeanor charges, except those involving motorized vehicles	Legal services and court representation prior to trial	Paid in full	\$60 per hour, up to \$400
	Court representation at trial	Paid in full	\$1,200 (Includes trial indemnity benefits of \$1,200 for up to three days of trial time)
Domestic violence Attorney's fees related to legal representation for the named insured to obtain a protective order related to domestic violence	Advice, office work, and representation	Paid in full	\$60 per hour, up to \$240
Driving privilege protection Representation of an insured in the defense of a traffic misdemeanor offense where conviction of the offense will directly result in the suspension or revocation of the insured's driving privileges	Legal services and court representation prior to trial	Paid in full	\$60 per hour, up to \$400
	Court representation at trial	Paid in full	\$1,200 (Includes trial indemnity benefits of \$1,200 for up to three days of trial time)
Driving privilege protection – minor traffic offense Minor traffic offenses where the insured's driving privileges are not at risk. Covered traffic offenses do not include charges of, or related to, driving while impaired by or under the influence of drugs or alcohol; nor are traffic offenses such as parking tickets, equipment violations, or any nonmoving violations covered under this benefit.	Limited to one use per member per calendar year	Paid in full	\$60 per hour, up to \$200
Driving privilege restoration Legal representation in administrative proceedings for the restoration of suspended or revoked driving privileges of an insured	For legal services and representation in hearings	Paid in full	\$60 per hour, up to \$240

Category definition	Covered services	Network attorney	Out-of-network attorney (Indemnity benefit)
Habeas Corpus proceedings	Legal representation in habeas corpus proceedings	Paid in full	\$60 per hour, up to \$300
Insanity or infirmity proceedings Legal defense in insanity or infirmity proceedings	Advice, office work and representation	Paid in full	\$1,800 (Includes trial indemnity benefits of \$1,200 for up to three days of trial time)
Juvenile court proceedings (except involving traffic matters) <ul style="list-style-type: none"> Legal defense of an insured child in juvenile delinquency proceedings Legal defense in juvenile delinquency proceedings regarding your parental responsibilities for an insured child 	Representation at administrative hearings and court representation	Paid in full	\$60 per hour, up to \$600
Major trial Representation at trial beginning on the fourth day of trial in covered court proceedings for which indemnity benefits are being provided		Included with covered benefits	\$400 per \$1/2 day of trial time, up to \$100,000
School administration hearings Attorney's fees for you related to legal disputes in primary and secondary education administrative proceedings regarding disabilities, special education, and student policy violations involving your dependent child	Initial advice and representation at administrative hearings, including appeals before administrative agencies	Paid in full	\$60 per hour, up to \$720

Exclusions and limitations

Benefits will not be paid for any legal matter that occurs or is initiated before the effective date of your coverage. ARAG defines preexisting as the first actual or alleged violation of your or any other party's legal rights or obligations resulting in a legal dispute or legal defense or your first contact with the attorney for your legal matter or the first court or administrative action regarding this legal matter, whichever is earlier.

In addition, the Group Legal Insurance plan does not cover services for the following:

- Legal services for matters against ARAG, the policyholder and/or Microsoft
- Legal services arising out of your profession, business interests, investment interests, occupation, employment, workers' or unemployment compensation, relocation required by an employer, patents or copyrights
- Legal services for the benefit of a person other than you or legal services for a person other than the named insured against the interests of another insured under the same certificate
- Costs related to title insurance, title search, title abstracting and any cost other than attorney fees

- Legal representation in class actions, interventions, judgments or appeals
- Legal representation deemed by the attorney to be lacking merit or representation that is, in the judgment of the providing attorney, in violation of attorney ethics rules
- Legal services related to any court action that is or can be brought in Small Claims Court or in a similar court of limited jurisdiction
- Legal disputes involving insurance contracts or related to structural damage(s), noise, visual or other intangible hindrances arising out of or affecting real estate property
- Legal disputes arising out of the inheritance law or involving contracts related to family law matters
- Legal services that are eligible to be paid by another party, allowed to be paid by law, involving punitive damage(s) claims or other matters normally handled by contingency fee
- Services which are not expressly listed under the [What the plan covers](#) section above

Telephone legal services cannot be provided for:

- Legal services for matters against ARAG, the policyholder and/or Microsoft
- Legal services arising out of your profession, business interests, investment interests, occupation, employment, workers' or unemployment compensation, relocation required by an employer, patents or copyrights
- Legal services, which in the opinion of the telephone network attorneys, may not ethically or appropriately be handled over the telephone
- Legal services for the benefit of a person other than you
- Matters which require, in your and/or the telephone network attorney's opinion, your personal presence in an attorney's office or your direct and personal representation by another attorney or specialist
- Immigration assistance services unless those services are specifically listed in your service agreement
- Legal services for a person other than the named plan member against the interests of another plan member
- Matters outside the jurisdiction of the United States or Canada

Reduced fee legal services cannot be provided for:

- Legal services for matters against ARAG, the policyholder and/or Microsoft
- Legal services arising out of your profession, business interests, investment interests, occupation, employment, workers' or unemployment compensation, relocation required by an employer, patents or copyrights
- Legal services for the benefit of a person other than you
- Legal representation deemed by the attorney to be lacking merit or representation that is, in the judgment of the providing attorney, in violation of attorneys' ethics rules



For a complete list of covered services and exclusions and limitations, call ARAG at (800) 331-3425.

How to file a claim

Benefits provided by in-network attorneys will be paid directly by ARAG on your behalf.

If you use an out-of-network attorney, follow these steps to file a claim and be reimbursed for covered benefits from the plan:

- Notify ARAG by calling (800) 331-3425 within 60 days of consulting the attorney
- Pay the attorney for the services you receive
- Contact ARAG and ask for the Non-Network Attorney Claim Form
- Submit the completed claim form, along with an itemized billing statement from the attorney.

ARAG must receive your form within 120 days of the legal expense for you to get reimbursed. The plan will reimburse you according to the fee schedule provided in the What the plan covers section.

If ARAG denies a claim, the plan member/attorney has an opportunity to provide additional information to support why they feel a denied claim should be covered. The plan member/attorney has 60 days in which to send in an appeal and additional supporting documentation. If the claim is still denied, the plan member/attorney receives a detailed description of why the matter was not covered.

You are entitled to a full and fair review of a denied claim. To request review of a denied claim, you must submit a written request for review within 180 days of the date of notice. Your request should include:

- Date of request
- Printed name and address (and name and address of authorized representative if you have designated one)
- Date of service in question
- Description of claim denied (claim number, if available)

ARAG will provide a written response within 60 days of receipt of your request.



Submit your written request for review to:

ARAG Claims Center
400 Locust, suite 480
Des Moines, IA 50309

Section XII: Group legal survivor support

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How the plan works

This customized legal program is administered by ARAG® provides assistance when an employee or dependent is faced with end of life decisions or immediately following the death of an employee or dependent. Eligibility includes employees, spouses/domestic partners, or dependents in addition to non-Plan participants who are acting as the official executor of the estate of an employee, spouse/domestic partner, or dependent who is covered under this Plan (the "Eligibles").

ARAG Network Attorneys are available to provide services to Eligibles. The fees for ARAG Network Attorneys are fully paid and unless otherwise stated, the Eligible will be responsible for payment of associated costs, such as filing fees, courts costs or postage.

If an Eligible chooses not to use a Network Attorney for the stated benefits, the Eligible may be eligible for an indemnity benefit as shown in the schedule below.

Eligibles are able to use the following services for a one-year time period from the date that Microsoft indicates member eligibility in the Microsoft Survivor Support Legal Program. A dedicated ARAG team member is available to provide assistance to Eligibles.

What the plan covers

Legal issue	Available service	Network attorney	Indemnity benefit
Will preparation	Includes preparation of the following: Individual will or husband and wife will(s). (Does not include any tax planning services done in connection with the will.)	Paid in full	\$150
Codicil	Change or amendment to an existing will.	Paid in full	\$40 single document \$60 spousal documents (2)
Living will	Legal services to create a living will for you and/or your spouse/domestic partner. A living will is a written document that contains a person's wishes regarding the use of extraordinary life-support or other life-sustaining medical treatment.	Paid in full	\$35 single document \$50 spousal documents (2)
Healthcare power of attorney	Legal services to create a healthcare power of attorney for you and/or your spouse/domestic partner. A healthcare power of attorney is a legal document you can create to grant someone permission to make medical decisions for you if you are unable to make those decisions yourself.	Paid in full	\$35 single document \$50 spousal documents (2)

Legal issue	Available service	Network attorney	Indemnity benefit
Financial power of attorney	Legal services to create a financial power of attorney for you and/or your spouse/domestic partner. A financial power of attorney is a legal document you can create to grant someone permission to make financial decisions for you if you are unable to make those decisions yourself.	Paid in full	\$40 single document \$60 spousal documents (2)
Sale of primary residence	Legal services including review of documents, preparation of final contract for sale and attendance at closing of your primary residence.	Paid in full	\$360*
Uncontested guardianship	Attorney's fees for representation for you in uncontested court proceedings for appointing or being appointed a guardian or conservator. This coverage does not include annual guardianship or conservatorship review.	Paid in full	\$300*
Estate administration	Legal services in administering an estate where you have been named the executor.	Paid in full	\$540*
General in-office services	General in-office legal services from an attorney for any legal issue that is not otherwise covered or excluded under this plan. Limited to 4 hours per year. If an eligible employee or dependent exceeds 4 hours of general in-office services, Network Attorneys will reduce their hourly rate by at least 25% for additional hours required to resolve the legal issue.	4 hours**	\$240*
Telephone legal advice	Toll-free telephone advice on how the law relates to your personal legal matter and which action may be taken.	Paid in full	NA

*Indemnity benefit/reimbursement amounts are paid at \$60 per hour up to the stated amounts unless stated as paid per document.

**For general in-office services that exceed 4 hours, Network Attorneys will take at least 25 percent off their regular hourly rate for any remaining hours required to resolve the legal issue.

Exclusions and limitations

The group legal survivor support benefit does not cover services for the following:

- Legal services for matters against ARAG, the plan sponsor, and/or your employer.
- Legal services arising out of your profession, business interests, investment interests, occupation, employment, workers or unemployment compensation, relocation required by an employer, patents or copyrights.
- Legal representation deemed by the attorney to be lacking merit or representation that is, in the judgment of the providing attorney, in violation of attorney ethics rules.

Telephone legal advice and consultation services are excluded for:

- Matters which require, in your and/or the telephone network attorney's opinion, your personal presence in attorney's office or your direct and personal representation by another attorney specialist (including an accountant).
- Matters outside the jurisdiction of the United States of America.



For a complete list of covered services and exclusions and limitations, call ARAG at (800) 247-4184 x269.

Section XIII: Coverage if you leave Microsoft

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When benefit coverage ends

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Microsoft reserves the right to *terminate or amend* these plans at any time and for any reason.

Medical, vision and prescription drugs

For employees

Your benefit coverage ends when any one of the follow occurs:

- The date this plan is terminated
- The date you no longer qualify as an eligible employee
- The first day following the maximum length of an applicable leave of absence, should you not return to work

For dependents

Coverage for dependents will end on the earliest of the following dates:

- The date your coverage ends
- The date the plan is terminated
- The date your dependent no longer meets the definition of an eligible dependent, including the following situations:
 - Divorce, legal separation, or annulment (for spouses)
 - The dissolution of a domestic partnership
 - The end of the month in which a child no longer meets the age requirement for dependent status
- The date coverage for all dependents under the plan is cancelled



If your coverage terminates as a result of your death, your dependent's coverage will continue through the end of the month you die if you die before the 15th of that month, or through the 15th of the next month if you die on or after the 15th of the month. If your coverage terminates as a result of your death Microsoft will provide your covered dependents, who elect COBRA a subsidy for 365 days from the date of their medical or dental coverage ends.

You may be eligible to continue your medical, vision, and dental coverage after you leave Microsoft. See the [Continuation of coverage for health benefits](#) section for more information.

If you live in Hawaii

If your principle residence is in Hawaii and you would otherwise lose medical coverage under the Hawaii Only Plan (Premera) while hospitalized or otherwise prevented by sickness from working, your medical coverage will not be terminated before whichever occurs later:

- The end of the third month following the month in which you first became unable to work due to hospitalization or sickness
- The date Microsoft ceases to pay you regular wages in such a case

During such period of continued coverage, Microsoft will contribute the same amount per month toward your cost of medical coverage that it contributed per month for you before you became sick.

Proof of coverage

Following the end of your employment from Microsoft, you will receive proof of your health coverage under the Microsoft plan in the mail. If you enroll in another health plan that has an exclusion period for preexisting conditions, you may need this proof of coverage to reduce the exclusion period. Your new plan will let you know if your new plan's exclusion period can be shortened and, if so, by how much.

Dental

Dental coverage will be extended for covered services that are ordered before your coverage ends if the covered service is delivered or completed within 30 days. This includes:

- Dentures
- Fixed bridgework
- Crown
- Root canal therapy



To be **considered an "ordered service"** the following must have been done:

3. Impressions used to form the dentures, crowns, or fixed bridgework have been taken
 4. The teeth have been fully prepared for fixed bridgework and crowns
-

For employees

Your benefit coverage ends when any one of the follow occurs:

- The date this plan is terminated
- The date you no longer qualify as an eligible employee
- The first day following the maximum length of an applicable leave of absence, should you not return to work

For dependents

Coverage for dependents will end on the earliest of the following dates:

- The date your coverage ends
- The date the plan is terminated
- The date your dependent no longer meets the definition of an eligible dependent, including the following situations:
 - Divorce, legal separation, or annulment (for spouses)
 - The dissolution of a domestic partnership
 - The end of the month in which a child no longer meets the age requirement for dependent status
- The date coverage for all dependents under the plan is cancelled



If your coverage terminates as a result of your death, your dependent's coverage will continue through the end of the month you die if you die before the 15th of that month, or through the 15th of the next month if you die on or after the 15th of the month. If your coverage terminates as a result of your death Microsoft will provide your covered dependents, who elect COBRA a subsidy for 365 days from date their medical or dental coverage ends.

You may be eligible to continue your dental coverage after you leave Microsoft. See the [Continuation of coverage for health benefits](#) section for more information.

Flexible spending accounts

Your coverage ends on the earliest of:

- The date this plan is terminated
- The date you no longer qualify as an eligible employee

You can claim eligible expenses that were incurred through your coverage end date for up to 90 days following the end of the plan year. Claims submitted more than 90 days after the end of the plan year are not eligible for reimbursement, and any money left in the account will be forfeited.

You may be eligible to continue participation in the health FSA after you leave Microsoft. See the [Continuation of coverage for health benefits](#) section for more information.

Employee or dependent life insurance



All benefits and coverages are subject to the terms of the [insurance certificates](#) under which the benefits are provided. If there is any conflict between the insurance certificates and this SPD, the certificate will always govern.

For employees

Your coverage ends on the earliest of:

- The date this plan is terminated
- The date you no longer qualify as an eligible employee
- The date the coverage or policy ends
- The date your employment ends
- The date you fail to make a required premium contribution

If your life insurance premium is waived because you become disabled, your coverage will not end solely because of either of the following:

- Your employer's coverage under the Group Contract ends
- The Employee Term Life coverage ends

For dependents

Your dependent's coverage will end on the earliest of the following dates:

- The date your coverage ends
- The date your dependent fails to meet this plan's definition of an eligible dependent

You may be eligible to continue coverage after you leave Microsoft. See the [Continuation of coverage for other benefits](#) section for more information.

Accidental death & dismemberment (AD&D)

A covered loss that started before the termination of coverage date will not be affected by the termination date.



All benefits and coverages are subject to the terms of the [insurance certificate](#) under which the benefits are provided. If there is any conflict between the insurance certificates and this SPD, the certificate will always govern.

For employees

Your coverage ends on the earliest of:

- The date this policy is terminated
- The end of the grace period if you do not pay the required premium
- The premium due date that falls on or follows the date you are no longer eligible for coverage

For dependents

Your child's coverage will continue as long as your coverage remains in effect and the child remains a dependent child incapable of self-sustaining employment.

Your dependent's coverage will end on the earliest of the following dates:

- The date your coverage ends
- The premium due date that falls on or follows the date your dependent is no longer eligible for coverage

If your child is no longer eligible for AD&D coverage, your dependent child can continue coverage if:

- On the date your child's coverage would otherwise terminate due to age, the child is incapable of self-sustaining employment because of mental retardation or physical handicap
- Proof of incapacity is provided within 31 days after the normal termination date
- Your coverage remains in effect.

You may be eligible to continue coverage after you leave Microsoft. See the [Continuation of coverage for other benefits](#) section for more information.

Long-term disability (LTD)

Your coverage ends on the earliest of:

- The date this plan is terminated
- The date you no longer qualify as an eligible employee

You may be eligible to continue coverage after you leave Microsoft. See the [Continuation of coverage for other benefits](#) section for more information.

Group legal

Coverage will continue for legal matters that began while the plan was still in effect until each covered matter is resolved, regardless of the length of time it takes to reach a resolution.

Your coverage ends on the earliest of:

- The date this plan is terminated
- The last day of the month in which you leave Microsoft
- The last day of the month in which you no longer qualify as an eligible employee



If you are a participant in the plan and you die, your spouse and dependents are covered under the plan through the end of the calendar year in which your death occurred.

If you have been enrolled in the Group Legal Plan for at least one year, you may be able to convert your Group Legal Plan coverage to a standard program. See the [Continuation of other coverage for other benefits](#) section for more information.

Continuation of coverage for health and FSA benefits (COBRA)

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How COBRA works

If you are no longer eligible for Microsoft benefits, you may be able to continue coverage of the following benefits on a self-pay basis under the Consolidated Omnibus Budget Reconciliation Act (COBRA):

- Medical, vision, and prescription drugs
- Dental
- In some cases, a health care or vision and dental flexible spending account (FSA)

Note: You may also have other health coverage options available to you through the Health Insurance Marketplace. Visit www.healthcare.gov for further information.

If you elect to continue medical coverage, you also have access to Employee Assistance Program (EAP) benefits.

You can continue coverage under COBRA for up to 18 months. In some cases, you may have the option to extend COBRA coverage.

With regard to benefits, COBRA participants have the same rights as employees. COBRA coverage is administered by BenefitConnect | COBRA (Towers Watson).



Your rights to COBRA coverage may change as further amendments to COBRA are made by Congress or as interpretations of COBRA are made by the courts and by federal regulatory agencies.

Who is eligible

COBRA coverage is available for you and your dependents if:

- You and your dependents were covered by Microsoft benefits on the day before a qualifying event occurs
- A child is born to you or adopted by you, while you are covered under COBRA

Qualifying events must result in the loss of benefit coverage for you or for your dependents. They include:

- The end of your employment with Microsoft for any reason other than gross misconduct
- Your death (if your coverage terminates as a result of your death Microsoft will provide your covered dependents, who elect COBRA a subsidy for 365 days from date their medical or dental coverage ends)
- Your divorce, legal separation, or annulment
- The legal dissolution of your same-sex domestic partnership
- The fact that a dependent is no longer an eligible dependent as defined by the Microsoft plan

You are eligible for COBRA continuation of coverage for the health flexible spending account (FSA) if your balance exceeds the premiums for health FSA COBRA coverage. Any unused amounts are forfeited at the end of the plan year, and you may not continue health FSA coverage for the next plan year. Cancellation of your health FSA COBRA coverage prior to the end of the plan year will terminate all COBRA coverage (medical, prescription drugs, vision, and dental).

You may elect separate COBRA coverage for you and each of your eligible dependents. If elected, separate coverage will apply to all of your COBRA benefits and separate premiums will apply to each member. The health FSA balance will be split among the members and each will have a separate annual limit. If you are interested in this alternative, contact BenefitConnect | COBRA at (877) 29-COBRA (26272) for more information.



If you elect COBRA medical coverage because you take a leave of absence from work or your employment ends as a result of an injury or illness covered by accidental death & dismemberment (AD&D) covered loss, you may receive up to 24 equal monthly payments to help you pay for COBRA continuation of medical coverage. Payments will stop if you become covered under another group medical plan. Each payment will equal the lesser of 3% of your benefit or \$125. Proof that the payment will be used for continuation of medical coverage will be required.



Removing a dependent during Open Enrollment is not a COBRA qualifying event so COBRA coverage will not be made available to the dropped dependent when they lose coverage on January 1st.

How to start COBRA coverage

If your employment with Microsoft is ending and you or your dependents are eligible for COBRA coverage, BenefitConnect | COBRA will send you or your dependent a notice about your right to COBRA coverage to your last known address or last known address of your dependent within 44 days of your last day of employment or notification of your death.

If coverage for you or your dependents is ending due to any other qualifying event (including divorce, legal separation, dissolution of a domestic partnership or dependent becoming ineligible), you or your dependent must inform Microsoft no more than 60 days after the latest of any one of the following events:

- The date of the qualifying event

- The date that benefits are terminated
- The date you or your dependent is informed, through the plan's SPD or the general COBRA notice, of his or her obligation to provide notice and the procedures for providing such notice



To notify Microsoft of a qualifying event, use the [Benefits Enrollment tool](#), contact Benefits, or call Benefits at (425) 706-8853.

If you report a qualifying event to Microsoft, but COBRA coverage is not made available at that time due to late reporting or gross misconduct, BenefitConnect | COBRA will send you a notice of unavailability within 14 days of receiving your notice of the event.

You must enroll for COBRA coverage within 60 days of the date your benefits end with Microsoft, or the date you are mailed your COBRA notification, whichever date is later. You can enroll in your current plan. And you can enroll yourself and or any eligible dependents. You do not have to cover the same dependents as you had as an eligible employee.



If you do not notify Microsoft within the 60-day period, you and your covered dependents will lose your right to COBRA coverage. If you do not choose COBRA coverage or do not pay for COBRA coverage within the time limits set by COBRA, you may not be eligible for COBRA coverage in the future for the same qualifying event.

Extending COBRA coverage

If a second qualifying event occurs during the 18-month COBRA period, your covered dependents may continue their coverage for a maximum of 36 months from the first qualifying event. Your dependents must notify Microsoft of this change within 60 days of the qualifying event.

If you become disabled before your qualifying event or during the first 60 days of your 18-month COBRA period, your COBRA coverage may be extended for up to 29 months if you receive confirmation from the Social Security Administration that your disability occurred within this timeframe. You must send this Social Security Administration notice indicating the disability onset date to BenefitConnect | COBRA no more than 60 days after the latest of any one of the following events:

- The date of the notice from the Social Security Administration
- The date of the qualifying event
- The date benefits are terminated
- The date the member is informed, through the plan's Summary Plan Description (SPD) or the general COBRA notice, of his or her obligation to provide notice, and the procedures for providing such notice
- Note: If you become entitled to Medicare less than 18 months before a qualifying event due to termination of employment, your eligible dependent can elect COBRA for a period of time of not more than 36 months from the date you became entitled to Medicare.

What you pay

If you enroll for COBRA coverage, you must pay the full cost of the coverage (employer and employee share) plus an administrative fee. Generally, this cost is 102% of the cost of coverage for similarly situated active full-time employees and/or dependents.

The cost is actuarially determined based on the level of coverage. Separate rates are established for:

- A single employee
- An employee and spouse/domestic partner
- An employee and children
- An employee, spouse/domestic partner, and children.

The COBRA rate is not the same as the rate used for active employees. If the cost of active employee coverage changes after your COBRA coverage starts, the cost of COBRA coverage will also change.

If you are disabled and qualify for an additional 11 months of coverage, the cost for the extra months of coverage is 150% of the actual cost for similarly situated active full-time employees and/or dependents.

You must send your first COBRA payment to BenefitConnect | COBRA postmarked within 45 days following the date you elect COBRA coverage.



Your monthly COBRA payments must be postmarked no more than 30 days following the due date. If your payments are late, you could lose COBRA coverage retroactive to the last payment date.

In the event of your death, Microsoft will provide your covered dependents a COBRA subsidy for medical and dental coverage (but not premiums for flexible spending account coverage) for up to the first 365 days from the date that they lose such coverage. Your dependents must elect COBRA continuation coverage under a Microsoft health care plan in order to avail of this benefit.



For more information about COBRA rates, contact BenefitConnect | COBRA at (877) 29-COBRA (26272)

The following table summarizes the monthly COBRA rates for 2016. These rates are subject to change. (All currency amounts are expressed in U.S. dollars.)

2016 COBRA rates					
Type of coverage	Employee or spouse/domestic partner	Employee and spouse/domestic partner	Employee and children	Employee and spouse/domestic partner and children	Children only
Medical, vision and prescription drugs					
Health Savings Plan (Premera)	\$479	\$960	\$719	\$1,391	\$240
Access Health Savings Plan (Premera)	\$479	\$960	\$719	\$1,391	\$240
Hawaii Only Plan (Premera)	\$515	\$1,031	\$773	\$1,494	\$258

HMO Plan (Group Health Cooperative)	\$424	\$850	\$638	\$1,232	\$214
HMO Plan (Kaiser Permanente)	\$524	\$1,049	\$787	\$1,311	\$262
Dental					
Dental Plus	\$67	\$135	\$102	\$196	\$35
Dental Basic	\$22	\$45	\$35	\$65	\$13

If your coverage terminates as a result of death Microsoft will provide a COBRA subsidy for 365 days from date of termination for medical and dental coverage.

Benefit coverage is subject to the terms and conditions set forth by Microsoft corporate policies, benefit plan documents, and summary plan descriptions.

Filing an appeal for COBRA coverage

If you believe your right to enroll in COBRA coverage should not have been denied, you may file an appeal as follows:

1. Write an appeal in which you explain why you believe your right to COBRA coverage was improperly denied. Include your name, address, and the names of other covered individuals you wish to include in your appeal, along with any additional information you wish to be reviewed.
2. Send your written appeal within 30 days of your receipt of the declination to:

BenefitConnect | COBRA Service Center
P.O. Box 919051
San Diego, CA 92191-9863
(877) 29-COBRA (26272) [(858) 703-3068 International callers only]

BenefitConnect | COBRA will respond within 30 days after the receipt of your written appeal. This is the exclusive process for appeals of COBRA rights declinations. Claims for COBRA coverage are not subject to the general plan and ERISA rules for benefit claims and appeals. BenefitConnect | COBRA's determination is final. You cannot appeal further.

When COBRA coverage ends

COBRA coverage ends on the date any one of the following events occur, whichever comes first:

- The date the maximum COBRA coverage period ends
- The last date for which premiums were paid, in the event that you fail to make the next required premium payment either in full or within the grace period required by COBRA
- The date you become covered under another group plan after the date of your COBRA election
- The date Microsoft ceases to offer the plan in which you are enrolled. However, COBRA coverage may be available under other Microsoft plans. If all Microsoft plans are terminated, all COBRA coverage is also terminated

- If you add dependents to your coverage while on COBRA, their coverage ends when your coverage ends



If the qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify BenefitConnect | COBRA of that fact within 30 days after the Social Security Administration's determination. All other rules still apply. COBRA participants will be notified of their COBRA termination date.

Continuation of coverage for other benefits

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You may be able to extend the following benefits if your coverage ends with Microsoft for reasons other than gross misconduct.


Employee or dependent life insurance

If your coverage under the Microsoft plan ends, you may convert your Microsoft insurance (a group policy) to an individual policy or apply for similar coverage under the portability plan. You may not choose both options. You and your qualified dependents must have been covered under the Microsoft life insurance plan when your coverage ends.

Conversion to individual policy

Your coverage may be converted to an individual policy if your employment ends. Dependent coverage may be converted to an individual policy if your employment ends, you die, or you divorce. Evidence of Insurability (EOI) is not required, but you must apply and pay for your converted coverage within 31 days after your employment ends.

The maximum amount you can convert to an individual life policy is the face amount of your employee or dependent term life insurance coverage when your group insurance coverage ends. Rates are based on your age and your class of risk. Dependent rates are based on your dependent's age and class of risk.

 For more information about converting to an individual policy, contact Prudential (800) 778-3827.

Continuation of coverage through the portability plan

You may be eligible to continue coverage through the portability plan if your coverage ends because you leave Microsoft or you otherwise become ineligible for continuing coverage. This coverage is not available if you fail to make contributions for the coverage, or the Prudential AD&D policy is replaced for all employees with a new policy for which you become eligible within 31 days.

You must be age 69 or younger to continue employee life insurance. You may continue dependent life insurance coverage only if you elect to continue your employee life insurance. If you die or divorce, your spouse or domestic partner will have the right to apply for continued life insurance coverage under the portability plan.

Portability is not available for the following dependents:

- Spouses or domestic partners age 70 or over
- Dependent children older than age 19, or 23 if enrolled as a full-time student in a school and wholly dependent on you for support and maintenance
- Dependents who are confined for medical care or treatment

The amount of insurance coverage that you can continue is:

- For employee coverage: from \$20,000 to \$1,000,000
- For dependent coverage: from \$20,000 to \$500,000

To continue coverage, submit your request in writing to Prudential within 31 days of when your coverage under the Microsoft plan ends. If you elect to continue your life insurance, coverage is effective at the end of the election period. You do not have to provide EOI to qualify for this continued insurance coverage; however, if you do provide EOI, you may pay lower premium rates.



For more information about the portability plan, contact Prudential (800) 778-3827.

Accidental death & dismemberment (AD&D)

You may be eligible to continue AD&D coverage under the portability plan if your insurance ends because you leave Microsoft or you otherwise become ineligible for continuing coverage. This coverage is not available if you fail to make contributions for the coverage, your employment ends because you retire, or the Prudential AD&D policy is replaced for all employees with a new policy for which you become eligible within 31 days.

Portability is not available for the following dependents:

- Spouses/domestic partners age of 80 or older
- Dependent children older than age 19, or 23 if wholly dependent on you for support and maintenance
- Dependents who are confined for medical care or treatment

The amount of insurance coverage that you can continue is:

- For employee coverage: from \$20,000 to five times your base pay or \$1,000,000, whichever is less
- For dependent coverage: from \$20,000 to \$500,000 or the coverage the dependent had when coverage with Microsoft ends, whichever is less

To continue coverage, submit your request in writing to Prudential within 31 days of when your coverage under the Microsoft plan ends.

If you elect to continue your life insurance, coverage is effective as of the date your coverage under the Microsoft Plan ends.



For more information about the portability plan, contact Prudential (800) 778-3827.

Long-term disability (LTD)

If your coverage under the Microsoft plan ends, you may purchase LTD coverage under Prudential's group conversion plan. You and your qualified dependents must have been covered under the Microsoft LTD plan for at least 12 consecutive months when your coverage ends.

You are not eligible to apply for coverage under Prudential's group conversion policy if:

- You are or become insured under another group long-term disability plan within 60 days after your employment ends
- You are disabled under the terms of the plan
- You are age 70 or more when your employment ends
- Your coverage under the plan ends for any of the following reasons:
 - The plan is canceled
 - You retire (applies when retirement is self-reported to Prudential)
 - The plan is changed to exclude the group of employees to which you belong
 - You are no longer in an eligible group
 - You fail to pay the required premium under this plan

You must apply for insurance under the conversion policy and pay the first premium to Prudential within 60 days after the date your employment ends. Evidence of insurability will be required for certain levels of coverage.

Your coverage under the conversion plan will not be more than your coverage under the Microsoft LTD plan, but it may be lower. The benefits will comply with any state laws or regulations that may apply.

Your rates for the conversion plan will be based on the form and amount of insurance provided, the period and your age at the time of conversion. Your premiums will not be due less often than quarterly, unless you agree to another frequency.



For more information about the conversion plan, contact Prudential (800) 778-3827.

Group legal

If you have been enrolled in the Group Legal Plan for at least one year, you may convert your coverage to a standard program. Your premium for coverage will be deducted from your checking or savings account or charged to your credit card each month.



Please contact ARAG directly or online within 30 days of your last day of employment and complete a conversion form. Call (800) 331-3425 or log onto the Benefits site and visit the [ARAG Legal Center](#).



Following the death of an insured employee, spouse and dependents are covered under the plan through the end of the calendar year in which the death occurred.

Section XIV: Additional resources

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Glossary

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General terms

Eligible employee—For purposes of determining eligibility to participate in the plan, a regular employee of Microsoft is an employee who is in an approved headcount regular employment position with Microsoft and is on the Microsoft U.S. payroll and is not a Retail Store Employee.

An approved headcount regular employment position is one that is:

- Authorized in writing during the Microsoft annual or out-of-cycle budgeting process as a regular employment position and is approved by an officer of Microsoft (or by a regional director for positions in subsidiaries of Microsoft)
- Reflected in the official Human Resources (HR) database of Microsoft or one of its subsidiaries as a regular employment position (for example, as hourly regular or salaried regular)

You are on the Microsoft U.S. payroll if you are paid from the Microsoft Payroll department located in the United States, and Microsoft withholds and pays U.S. employment taxes on your payroll amounts. For purposes of eligible employee status, the term Microsoft includes those subsidiaries and affiliates of the Microsoft Corporation that participate in the Plan. The current participating employers are listed in the Administrative Information section of this Summary Plan Description. Contact Benefits if you would like a current list of the Microsoft subsidiaries and affiliates that participate in the Plan.

Notwithstanding the above, the following persons are not eligible employees and are not eligible to participate in the plan even if they meet the definition of a regular employee of Microsoft:

- Interns and visiting researchers
- Cooperatives
- Apprentices
- Nonresident aliens receiving no U.S. source income from Microsoft
- Employees covered by a collective bargaining agreement resulting from negotiations with Microsoft in which retirement benefits were the subject of good faith bargaining and participation in this plan was not provided for
- Persons providing services to Microsoft pursuant to an agreement between Microsoft and any other individual or entity, such as a staff leasing organization (leased employees)
- Temporary workers engaged through or employed by temporary or leasing agencies
- Temporary employees of Microsoft. For purposes of the plan, a temporary employee of Microsoft is one who is hired by Microsoft as an employee to work on a specific project or series of projects that in the aggregate is not expected to exceed six months.

- Workers who hold themselves out to Microsoft as being independent contractors or as being employed by or engaged through another company while providing services to Microsoft
- Project-based employees. For purposes of the plan, a project-based employee is one who is hired to work on a project or series of projects, is employed for a limited term, and has signed a Project-Based Employment Agreement.

Dependent children under age 26—Includes your:

- Biological child and/or your spouse's/domestic partner's biological child
- Child for whom you or your spouse/domestic partner has been named legal guardian as appointed by the courts (or recognized as guardian by the state of residence)
- Legally adopted child, or child who has been placed with you for adoption, but not a foster child
- A child's eligibility as a dependent does not rely on the child's financial dependency (on you or any other person), residency with you or with any other person, student status, employment, eligibility for other health plan coverage, or any combination of these factors.

Incapacitated dependent children age 26 or over—An incapacitated dependent is unable to sustain employment due to a developmental disability or physical handicap that existed before the child reached age 26. The individual is chiefly dependent on the member for support.

Spouse—You must be married to an employee (whether same or opposite sex of the employee) under the laws of any U.S. or foreign jurisdiction having the legal authority to sanction marriages, and not legally separated

Domestic Partner—You and your domestic partner (either of the same or opposite sex) must meet all of the following requirements:

- You are each other's sole domestic partner and intend to remain so indefinitely
- Neither of you is legally married
- You are both at least 18 years of age and are mentally competent to consent to contract
- You are not related by blood to a degree of closeness that would prohibit legal marriage in the state in which you legally reside
- You reside together in the same residence and intend to do so indefinitely (excepting a temporary residence change of not more than 90 days during which you and your domestic partner reside in separate homes)
- You are mutually responsible (financially and legally) for each other's common welfare

For life and accidental death & dismemberment (AD&D), a domestic partner includes any person who satisfies the requirements for being a domestic partner, registered domestic partner, or civil union partner of an eligible employee under the law of your jurisdiction of residence.

Health plan terms

Medical Care

Approved transplant center—A hospital or other provider that has developed expertise in performing solid organ transplants, bone marrow reinfusion, or stem cell reinfusion, and is approved by your insurance plan. Your plan has contractual agreements with approved transplant centers, and has access to a special network of approved transplant centers, throughout the United States. Whenever medically

possible, they will direct you to an approved transplant center with which they have a contract. Of course, if neither a plan-approved transplant center nor a network transplant center can provide the type of transplant you need, this benefit will cover a transplant center that meets the approval standards that are set by the plan.

Bluecard - BlueCard® Program and other inter-plan arrangements

Premera Blue Cross has relationships with other Blue Cross and/or Blue Shield Licensees generally called "Inter-Plan Arrangements." They include "the BlueCard Program," negotiated National Account arrangements, and arrangements for payments to non-network providers. Whenever you obtain healthcare services outside Washington and Alaska or in Clark County, Washington, the claims are processed through one of these arrangements. You can take advantage of these Inter-Plan Arrangements when you receive covered services from hospitals, doctors, and other providers that are in the network of the local Blue Cross and/or Blue Shield Licensee, called the "Host Blue" in this section. At times, you may also obtain care from non-network providers. Our payment calculation practices in both instances are described below.

It's important to note that receiving services through these Inter-Plan Arrangements does not change covered benefits, benefit levels, or any stated residence requirements of this plan.

Network Providers

When you receive care from a Host Blue's network provider, you will receive many of the conveniences you're used to from Premera Blue Cross. In most cases, there are no claim forms to submit because network providers will do that for you. In addition, your out-of-pocket costs may be less, as explained below.

BlueCard in California

We have made an arrangement for you as a Premera Blue Cross member with Anthem Blue Cross. In order for you to maximize your savings under the BlueCard Program, you will need to choose only Anthem Blue Cross network providers for services received in California.

Negotiated National Account Arrangement in Arizona

Members' claims for covered healthcare services in Arizona are processed through an Inter-Plan Program called a negotiated National Account arrangement with the Host Blue in Arizona. Our responsibilities and those of the Arizona Host Blue and its network providers under this arrangement are the same as under the BlueCard Program.

Allowable charge calculations under the negotiated National Account arrangement are the same as described above in the "Network Providers" section for the BlueCard Program.

Non-Network Providers

The allowable charge for Washington or Alaska providers that don't have a contract with us is the least of the three amounts shown below. The allowable charge for providers outside Washington or Alaska that don't have a contract with us or the local Blue Cross and/or Blue Shield Licensee is also the least of the three amounts shown below:

- An amount that is no less than the lowest amount we pay for the same or similar service from a comparable provider that has a contracting agreement with us
- 125% of the fee schedule determined by the Centers for Medicare and Medicaid Services (Medicare), if available
- The provider's billed charges

Notwithstanding any provision of the plan to the contrary, the plan will pay any amounts required by applicable law.

Exceptions Required by Law

In some cases, federal law or the laws in a small number of states may require the Host Blue to include a surcharge as part of the liability for your covered services. If either federal law or any state laws mandate other liability calculation methods, including a surcharge, we would then use the surcharge and/or other amount that the Host Blue instructs us to use in accordance with those laws as a basis for determining the plan's benefits and any amounts for which you are responsible.

BlueCard Worldwide®

If you're outside the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands, you may be able to take advantage of BlueCard Worldwide when accessing covered health services. BlueCard Worldwide is unlike the BlueCard Program available in the United States, the Commonwealth of Puerto Rico, and the U.S. Virgin Islands in certain ways. For instance, although BlueCard Worldwide provides a network of contracting inpatient hospitals, it offers only referrals to doctors and other outpatient providers. Also, when you receive care from doctors and other outpatient providers outside the United States, the Commonwealth of Puerto Rico and the U.S. Virgin Islands, you'll typically have to submit the claims yourself to obtain reimbursement for these services.

Further Questions?

If you have questions or need more information about Inter-Plan Arrangements, including the BlueCard Program, please call our Customer Service Department. To locate a provider in another Blue Cross and/or Blue Shield Licensee service area, go to our Web site or call the toll-free BlueCard number; both are shown on the back cover of your booklet. You can also get BlueCard Worldwide information by calling the toll-free phone number.

Brand-name prescription drug—A prescription drug that is sold under a trademark name. An equivalent generic drug may or may not be available at lower cost, depending upon whether the patent on the brand-name drug has expired.

Brand formulary—The brand-name prescription drugs that are covered under the Group Health HMO Plan.

Chemical dependency—This is an illness characterized by a physiological or psychological (or both) dependency on a controlled substance and/or on alcoholic beverages, and where the member's health is substantially impaired or endangered or his or her social or economic function is substantially disrupted.

Congenital anomaly—A marked difference from the normal structure of a body part that is physically evident from birth

Continuous care—Skilled nursing care provided in the home during a period of crisis in order to maintain the terminally ill member at home

Custodial care—Any service, procedure or supply that is provided primarily:

- For ongoing maintenance of a person's condition, not for therapeutic value, in the treatment of an illness or injury
- To assist a person in meeting activities of daily living for example, assistance in walking, bathing, dressing, eating and preparation of special diets and supervision over self-administration of medication not requiring the constant attention of trained medical personnel

Such services and supplies are regarded as custodial without regard to the following:

- Who prescribes the service and supplies
- Who recommends the service and supplies
- Who performs the service or the method in which such services are performed

Dentally necessary—A service or supply that meets all of the following Premera requirements. It is essential to, consistent with, and provided for the diagnosis or the direct care and treatment of a disease, accidental injury, or condition harmful or threatening to the enrollee's dental health, unless provided for preventive services when specified as covered under this plan

- It is appropriate and consistent with authoritative dental or scientific literature
- It is not primarily for the convenience of the enrollee, the enrollee's family, the enrollee's dental care provider or another provider
- It is not primarily for research or data accumulation

The fact that the covered services are furnished, prescribed, or approved by a dental care provider does not in itself mean that the services are dentally necessary.

Experimental or investigational—Such services include a treatment, procedure, equipment, drug, drug usage, medical device, or supply that meets one or more of the following criteria as determined by Premera or Group Health (for Kaiser related information refer to the Kaiser EOC):

- There is insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved.
- A drug or device that cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration (FDA) and has not been granted such approval on the date that the service is provided
- The service is subject to oversight by an Institutional Review Board.
- No credible scientific evidence demonstrates that the service is effective, in clinical diagnosis, evaluation, management, or treatment of the condition.
- Evaluation of credible scientific evidence indicates that additional research is necessary before the service can be classified as equally or more effective than conventional therapies.

Credible scientific evidence includes, but is not limited to, reports and articles published in authoritative peer-reviewed medical and scientific literature, generally recognized by the relevant medical community and assessments and coverage recommendations published by the Blue Cross and Blue Shield Association Technical Evaluation Center.

However, exclusions for experimental or investigational treatment will not apply with respect to services or supplies (other than drugs) that are received in connection with the treatment of a disease, if Premera or Group Health determines the following:

- The disease can be expected to cause death within one year, in the absence of effective treatment, and
- As demonstrated by scientific data, the care or treatment is effective or shows promise of being effective for the treatment of the disease

In making this determination, Premera or Group Health will take into account the results of a review by a panel of independent medical professionals. Panel members will be selected by Premera or Group Health. The panel will include professionals who treat the type of disease involved.

Also, exclusions for experimental or investigational treatment will not apply with respect to the drugs that meet any one of the following criteria:

- The drug or drugs have been granted the status of "treatment investigational new drug" or "group treatment investigational new drug"
- The drug or drugs are being studied at the Phase III level in a national clinical trial sponsored by the National Cancer Institute
- Premera determines that available scientific evidence demonstrates that the drug or drugs are effective or show promise of being effective in the treatment of the disease

Generic maintenance medications have a common indication for the treatment of a chronic disease (such as diabetes, high cholesterol, or hypertension). Indications are obtained from the product labeling. They are used for diseases when the duration of the therapy can reasonably be expected to exceed one year. A generic prescription drug is manufactured and distributed after the brand-name drug patent of the innovator company has expired, and is available at a lower cost than brand-name prescriptions. Generic drugs have obtained an AB rating from the U.S. Food and Drug Administration and are considered by the FDA to be therapeutically equivalent to the brand-name product.

Generic drugs are equivalent to brand-name drugs but are available at a lower cost because the patent has expired.

Hospice care—A coordinated program of palliative and supportive care for dying members by an interdisciplinary team of professionals and volunteers centering primarily in the member's home.

Intermittent care—Care provided due to the medically predictable recurring need for skilled home health care services.

Out-of-network—Physicians, hospitals and other providers who have not contracted with Premera or Group Health. If you receive services from an out-of-network provider or facility, then you will typically have a higher coinsurance and you are responsible for the difference between the provider's billed charge and the allowable charge.

Physical functional disorder—A limitation from normal (or baseline level) of physical functioning that may include, but is not limited to, problems with ambulation, mobilization, communication, respiration, eating, swallowing, vision, facial expression, skin integrity, distortion of nearby body parts or obstruction of an orifice. The physical functional impairment can be due to structure, congenital deformity, pain, or other causes. Physical functional impairment excludes social, emotional and psychological impairment or potential impairment.

Physician—A state-licensed:

- Doctor of Medicine and Surgery (M.D.)
- Doctor of Osteopathy (D.O.)

In addition, professional services provided by one of the following types of providers will be treated as physician services under this plan to the extent the provider is providing a service that is within the scope of his or her state license and providing a service for which benefits are specified in this plan and would be payable if the service were provided by a physician as defined above:

- Chiropractor (D.C.)
- Dentist (D.D.S. or D.M.D.)
- Optometrist (O.D.)

- Podiatrist (D.P.M.)
- Psychologist (Ph.D.)
- Advanced Registered Nurse Practitioner (A.R.N.P.)
- Nurse (R.N.)
- Naturopathic physician (N.D.)

Preventive Care—This plan covers preventive care as described below. “Preventive care” is a specific set of evidence-based services expected to prevent future illness. These services are based on guidelines established by government agencies and professional medical societies as required under the Affordable Care Act.

Preventive services have limits on how often you should get them and many of these limits are specific to gender, age or your personal risk factors for disease or condition. These limits are based on your age and gender. Some of the services you get as part of a routine exam may not meet preventive guidelines and would be covered as part of medical benefits.

The plan covers the following as preventive services:

- Covered preventive services include those with a Services with an “A” or “B” rating by the United States Preventive Task Force (USPTF);
- immunizations recommended by the Centers for Disease Control and Prevention and as required by state law; and
- preventive care and screening recommended by the Health Resources and Services Administration (HRSA).

Prescription drug—Any medical substance that cannot be dispensed without a prescription according to federal law. Only medically necessary prescription drugs are covered by this plan.

Respite care—Continuing to provide care in the temporary absence of the member’s primary caregiver or caregivers.

Skilled home health care—Home skilled nursing is reasonable and necessary care for treatment of an illness or injury that requires the skill of a nurse or therapist—based on the complexity of the service and the condition of the member. Services are performed directly by an appropriately licensed professional provider.

Skilled nursing care—Provided by a registered nurse (RN) or licensed practical nurse (LPN) and the care must require the technical proficiency, scientific skills, and knowledge of an RN or LPN. The need for skilled nursing is determined by the condition of the patient, the nature of the services required, and the complexity or technical aspects of the services provided. Nursing care is not skilled simply because an RN or LPN delivers it or because a physician orders it.

Specialty drugs—High-cost drugs, often self-injected and used to treat complex or rare conditions, including rheumatoid arthritis, multiple sclerosis, and hepatitis C. Specialty drugs may also require special handling or delivery. These medications can be dispensed only for up to a 30-day supply.

Urgent care—

- In the Premera health plans, a visit that is billed and covered at the same rate as an office visit with your regular physician and is a cost-effective option when you have an urgent need for care. Urgent care is the best option for treatment of a sudden illness, injury or condition that:
 - Requires prompt medical attention to avoid serious deterioration of the member’s health

- Does not require the level of care provided in the emergency room or a hospital
- Cannot be postponed until the member's physician is available
- In the Group Health HMO plan, the sudden, unexpected onset of a medical condition that is of sufficient severity to require medical treatment within 24 hours of its onset.

Value-based drugs—Drugs for chronic disease management such as diabetes, hyperlipidemia, heart failure and hypertension that are considered high value and are covered on a lower cost share tier.

Plan Management

Allowable charge—

- In the Premera health plans, the negotiated amount that in-network providers have agreed to accept as payment in full for a covered service. The allowable charge for Washington or Alaska providers that don't have a contract with us is the least of the three amounts shown below. The allowable charge for providers outside Washington or Alaska that don't have a contract with us or the local Blue Cross and/or Blue Shield Licensee is also the least of the three amounts shown below:
 - An amount that is no less than the lowest amount we pay for the same or similar service from a comparable provider that has a contracting agreement with us
 - 125% of the fee schedule determined by the Centers for Medicare and Medicaid Services (Medicare), if available
 - The provider's billed charges

Notwithstanding any provision of the plan to the contrary, the plan will pay any amounts required by applicable law. Out-of-network providers may not accept the allowable charge as payment in full. You are responsible for paying the difference between the allowable charge and the amount your out-of-network provider charges. In the Premera medical and dental plans, only the allowable charge will be applied to your deductible, coinsurance maximum, and out-of-pocket maximum, as applicable.

- In the Group Health HMO plan, the level of benefits that are payable by Group Health when expenses are incurred from a community provider. Expenses are considered an allowed amount if the charges are consistent with those normally charged to others by the provider or organization for the same services or supplies; and the charges are within the general range of charges made by other providers in the same geographical area for the same services or supplies. Members shall be required to pay any difference between the community provider's charge for services and the allowed amount.

Appeal—A written request to reconsider a written or official verbal adverse determination to deny, modify, reduce or end payment, coverage or authorization of health care coverage or eligibility to participate in the plan. This includes admissions to, and continued stays in, a facility. The process also applies to Flexible Spending Account appeals for reimbursement but does not apply to appeals of denied COBRA eligibility claims.

Case management—Assistance available in the Premera medical plans to help ensure that you receive appropriate and cost-effective medical care.

The benefits of this plan do not require preauthorization for coverage. You must be eligible on the dates of service, and services must be medically necessary. We encourage you to call Premera Customer Service to verify that you meet the required criteria for claims payment, and to help us identify admissions that might benefit from case management.

A case manager will work cooperatively with you and your physician to consider effective alternatives to hospitalization and other high-cost care in order to make more efficient use of plan benefits. This process

may include a flexible benefits option. Through the flexible benefits option, case managers may identify a less costly alternative treatment plan for the member. If you and your provider agree with the plan, alternative benefits may begin immediately. You will be asked to sign an alternative benefits agreement that includes certain conditions:

- Your participation in a treatment plan that is managed by case management is free, voluntary, and is based on a mutual agreement between you, your provider, and Premera Blue Cross
- If an agreement is reached, you or your legal representative, your physician, and other providers who are participating in the treatment plan will be required to sign written agreements that set forth the terms under which flexible benefits will be provided for a specified period of time
- Case management is subject to the terms set forth in the signed written agreements. Case management may utilize flexible benefits options as specified in the signed written agreements. Those agreements are not to be construed as a waiver of our right to administer the plan in strict accordance with its terms in other situations not covered by the written agreements.
- Each party has the right to propose changes to, or terminate, the alternative benefits agreement at any time at that party's discretion. To terminate the agreement, a party must provide written notice that the agreement is being terminated to the other party or parties' last known mail or e-mail address. Termination of a case management agreement does not affect your remaining benefits under this plan.

Coinsurance—The percentage of the allowable charge that you are required to pay for certain covered services.

Coinsurance maximum—The maximum amount that you could pay each year in coinsurance amounts for covered services. If you seek care with out-of-network providers, only the allowable charge applies to the coinsurance maximum.

Copayment—A fixed, up-front dollar amount that you're required to pay for certain covered services.

Deductible—The amount of covered medical costs you must pay each calendar year before the plan begins to pay its share of allowable charges.

Evidence of Coverage (EOC)—A document outlining details of benefits coverage under the Kaiser Permanente HMO Plan.

Explanation of benefits statement (EOB)—The statement you receive from Premera Blue Cross, Group Health Cooperative, or Kaiser Permanente detailing how much the provider billed, how much (if any) the plan paid, and the amount that you owe the provider (if any).

Health Maintenance Organization (HMO)—A health care plan such as Microsoft offers with Group Health Cooperative or Kaiser Permanente that covers only those services and supplies that are received from in-network providers and facilities. Out-of-network care is covered only under a few circumstances. Providers are all part of the same integrated health care system, so they can quickly share your medical records to help make informed decisions about care.

Independent review organization (IRO)—An independent organization of medical experts who are qualified to review medical and other relevant information.

In-network—Physicians, hospitals and other providers who have contracted with your plan administrator (Premera, Group Health Cooperative or Kaiser Permanente) to provide services at a negotiated discount rate. In-network providers agree to accept network rates and will not bill you for any amount in excess of

those rates. In-network providers also agree to bill your medical plan directly, so you will not have to pay up front and submit your own claim to Premera for reimbursement.

Lifetime benefit maximum—The maximum amount a plan will pay toward a benefit for a member. A benefit will pay only up to the lifetime maximum once. If your employment ends and you are rehired, the accumulated amount for that benefit carries over to your new enrollment.

Medically necessary—A covered service or supply that meet certain criteria including:

- It is essential to the diagnosis or the treatment of an illness, accidental injury, or condition that is harmful or threatening to the enrollee's life or health, unless it is provided for preventive services when specified as covered under this plan.
- It is appropriate for the medical condition as specified in accordance with authoritative medical or scientific literature and generally accepted standards of medical practice.
- It is a medically effective treatment of the diagnosis as demonstrated by the following criteria:
 - There is sufficient evidence to draw conclusions about the positive effect of the health intervention on health outcome
 - The evidence demonstrates that the health intervention can be expected to produce its intended effects on health outcomes
 - The expected beneficial effects of the health intervention on health outcomes outweigh the expected harmful effects of the health intervention.
- It is cost-effective, as determined by being the least expensive of the alternative supplies or levels of service that are medically effective and that can be safely provided to the enrollee. A health intervention is cost-effective if no other available health intervention offers a clinically appropriate benefit at a lower cost.
- It is not primarily for research or data accumulation.
- It is not primarily for the comfort or convenience of the enrollee, the enrollee's family, the enrollee's physician or another provider.
- It is not experimental or investigational.
- It is not recreational, life-enhancing, relaxation or palliative therapy, except for treatment of terminal conditions.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature that is generally recognized by the relevant medical community, Physician Specialty Society recommendations, the views of physicians practicing in relevant clinical areas, and any other relevant factors.

Out-of-pocket maximum—The maximum amount that you could pay each plan year for covered services and supplies.

Prior authorization—An advance determination by Premera or Group Health that the service is medically necessary and that the member's plan has benefits available for the service being requested. This determination is offered in certain situations where medical records must be provided to establish medical necessity before the plan will pay for the service. Services are subject to eligibility and benefits at the time of service.

Prior authorization is available for services that include (but are not limited to) the following:

- Scheduled admission into hospitals or skilled nursing facilities
- Advanced imaging, such as MRIs and CT scans

- Some planned outpatient procedures, such as facility sleep studies and varicose vein treatment
- Some injectable medications you get in a health care provider's office, such as Interferon, Synagis and Xolair
- Knee arthroscopy or knee arthroplasty
- Hysterectomy
- Home medical equipment costing \$500 or more

Examples of services where prior authorization is not necessary:

- Maternity care
- Hospital admissions for childbirth and newborn care
- Emergency admissions to hospital
- Emergency room or urgent care services
- Routine preventive care
- Physical therapy and chiropractic care
- Specialist or illness exams with a physician

Qualified Medical Child Support Order (QMCSO)—An order or judgment from a court or administrative body directing the plan to cover the child of a member as required by applicable law.

Residential treatment center or services—Facility-based treatment providing active treatment in a controlled environment. At least weekly physician visits are required and services must offer treatment by a multi-disciplinary team of licensed professionals.

Standard reference compendia—Refers to the American Hospital Formulary Service—Drug Information; the American Medical Association Drug Evaluation; the United States Pharmacopoeia—Drug Information, or other authoritative compendia as identified from time to time by the Federal Secretary of Health and Human Services. "Peer-reviewed medical literature" means scientific studies printed in health care journals or other publications in which original manuscripts are published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts. Peer-reviewed medical literature does not include in-house publications of pharmaceutical manufacturing companies.

Urgent situation—When an appeal is under consideration, a situation in which your provider concludes that the application of the standard time periods for making determinations could seriously jeopardize your life or health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed without the care or treatment.

Coordination of benefits terms

Coordination of benefits (COB)—A process where you or your covered dependents who have health benefit coverage through another employer, a government plan, or other motor vehicle or liability insurance, combine coverage to maximize benefits. All of your Microsoft health benefits—medical, dental, and vision—are subject to COB. The two plans coordinate their payment of benefits to ensure the total paid by both plans will not exceed the total amount charged.

Explanation of benefits statement (EOB)—The statement you receive from Premiera Blue Cross, Group Health Cooperative, or Kaiser Permanente detailing how much the provider billed, how much (if any) the plan paid, and the amount that you owe the provider (if any).

Primary plan—The health plan that pays benefits first when a member has coverage from more than one health plan.

Secondary plan—The health plan that pays benefits second when a member has coverage from more than one health plan. The secondary plan pays the balance for eligible expenses, subject to its plan benefits and limitations.

Long-term disability (LTD) terms

Absence of legal capacity—An individual is no longer able to act on his or her own behalf. Ultimately, the individual is not able to execute legal documents.

Activities of daily living—

- Bathing—Washing oneself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower
- Continence—The ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel and bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag)
- Dressing—Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs
- Eating—Feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or by feeding tube or intravenously
- Toileting—Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene
- Transferring—Sufficient mobility to move into or out of a bed, chair, or wheelchair or to move from place to place, either by walking, using a wheelchair, or by other means

Chronic illness or disability—One in which there is one of the following:

- A loss of the ability to perform, without substantial assistance, at least two activities of daily living for a period of at least 30 consecutive days
- A severe cognitive impairment, which requires substantial supervision to protect the family member from threats to health and safety, for a period of at least 30 consecutive days

Confined or confinement—As related to the Maximum Period of Payment benefit, a hospital stay of at least eight hours per day.

Continued health care coverage costs means the actual costs to you for continued health care coverage provided through your employer, and which you elect under COBRA or similar state law.

Cognitive impairment—A loss or deterioration in intellectual capacity that is:

- Comparable to and includes Alzheimer's disease and similar forms of irreversible dementia
- Measured by clinical evidence and standardized tests that reliably measure impairment in the individual's short-term or long-term memory, orientation as to person, place, or time; and deductive or abstract reasoning

Disability earnings—The earnings you receive while you are disabled and working, plus the earnings you could receive if you were working to your greatest extent possible. This would be, based on your restrictions and limitations, as follows:

- During the first 24 months of disability payments, the greatest extent of work you are able to do in your regular occupation that is reasonably available
- Beyond 24 months of disability payments, the greatest extent of work you are able to do in any occupation that is reasonably available, for which you are reasonably fitted by education, training, or experience

Earnings calculation date—Your Earnings Calculation Date is defined as the latest of (1) the date you meet the definition of disability under the Group Contract; (2) the date you commence an approved disability leave of absence or workers' compensation leave of absence; or (3) if you do not complete the 182-day elimination period within one year (365 days) from the date you met the definition of disability, and as a result you have to start a new 182-day elimination period, the date immediately preceding commencement of the new 182-day elimination period.

Elimination period—182 days of continuous disability from your injury or onset of your illness or when you've exhausted your short-term disability benefits, whichever is later, which must be satisfied before you are eligible to receive benefits from Prudential. If you become covered under a group LTD plan that replaces this plan during your elimination period, your elimination period under this plan will not be met.

Gainful occupation—An occupation, including self-employment, that can be expected to provide you with an income within 12 months of your return to work that exceeds your LTD payment, if you are not working, or 80% of your monthly earnings, if you are working.

Gross LTD payment—The benefit amount before Prudential subtracts deductible sources of income and disability earnings.

Indexed monthly earnings—Your monthly earnings, adjusted by the lesser of 10% or the current annual percentage increase in the Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W). Adjustments are made on each July 1, provided you were disabled for all of the 12 months before that date. Your indexed monthly earnings may increase or remain the same, but will never decrease.

Material and substantial duties—Those duties normally required as part of a job that cannot be reasonably omitted or modified. If you are required to work on average more than 40 hours per week, you are considered able to meet this duty if you are able to work 40 hours per week.

Monthly earnings—Is your gross monthly income just prior to the Earnings Calculation Date. Monthly earnings includes your base salary and the average commissions, bonuses and overtime pay earned per month during the shorter of: (i) the 12-month period just prior to the later of your Earnings Calculation Date; or (ii) your period of employment. Monthly earnings income does not include income received from any other extra compensation, or income received from sources other than Microsoft. If you become disabled while you are on a covered layoff or leave of absence, we will use your monthly earnings from your Employer in effect just prior to the date your absence begins.

Monthly payment—The payment you may receive if you become disabled while covered by this plan.

Preexisting Condition—You have a preexisting condition if both 1 and 2 are true:

1. You received medical treatment, consultation, care or services, including diagnostic measures, or took prescribed drugs or medicines, or followed treatment recommendation in the three months just prior to your effective date of coverage or the date an increase in benefits would otherwise be available
2. Your date of disability begins within 12 months of the date your coverage under the Plan becomes effective.

Recurrent disability—An injury or illness that worsens and is due to one or more of the same causes as a prior disability for which Prudential made a LTD payment.

Regular care—

- You personally visit a doctor as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat your disabling condition or conditions
- You are receiving the most appropriate treatment and care, which conforms with generally accepted medical standards, for your disabling condition or conditions by a doctor whose specialty or experience is the most appropriate for your disabling condition or conditions, according to generally accepted medical standards

Salary continuation or accumulated sick leave—Continued payments to you by Microsoft of all or part of your monthly earnings, after you become disabled as defined by the Group Contract. This continued payment must be part of an established plan maintained by Microsoft for the benefit of an employee covered under the Group Contract. Salary continuation or accumulated sick leave does not include compensation paid to you by Microsoft for work you actually perform after your disability begins. Such compensation is considered disability earnings, and would be taken into account as such, in calculating your monthly payment.

Substantial assistance—One of the following:

- The physical assistance of another person without which the family member would not be able to perform an activity of daily living
- The constant presence of another person within arm's reach who is necessary to prevent, by physical intervention, injury to the family member while the family member is performing an activity of daily living

Substantial supervision—Continual oversight that may include cueing by verbal prompting, gestures, or other demonstrations by another person, and that is necessary to protect you or the family from threats to your or the family member's health or safety.

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You may also contact Benefits by e-mail at benefits@microsoft.com or by phone at (425) 706-8853.

Medical and vision

Premera plans

If you want to...	Go here...
Review information about using the Health Savings Plan and the Health Savings Account (HSA)	Health Savings Plan Health Savings Account Guide to Benefits
Find Premera network providers	Premera Provider Directory
Compare price estimates, provider ratings, and hospital quality measures for providers in your area	Castlight Health
Find the cost of prescription medications	My Rx Choices
Pay for health care expenses directly from your HSA, FSA, or your personal bank account	Premera Bill Pay (For Health Saving Plan only)
Access your HSA and view your balance	My Dashboard
Review HSA investment options	Investing My HSA
Submit medical claims for out-of-network providers	Obtain a claim form here or by sending an e-mail to Premera. Return completed claim forms to: Premera Blue Cross Mailing address: P.O. Box 91059 Seattle, WA 91059 Fax: (800) 676-1477 Group Number: 1000010
Ask questions about the Health Savings Plan, HSA, or the Hawaii Only Plan	Contact Premera Blue Cross at microsoft@premera.com or (800) 676-1411. Group Number: 1000010

If you want to...	Go here...
Contact an experienced, registered nurse for help making health care decisions	Call the 24-hour Nurse Line at (800) 676-1411. The Nurse Line is available 24 hours a day, seven days a week. For deaf or hard-of-hearing access, call the TTY service at 711, provide the number above and choose option 2. Visit the Benefits site for more information on the Nurse Line.
Get expert medical advice on an important medical decision, such as whether to have surgery or confirming diagnosis of a condition such as cancer or other complex medical issues	Call the Expert Medical Opinion program, administered by Best Doctors, at (800) 676-1411. Visit the Benefits site for more information on the Expert Medical Opinion program.

HMO plan (Group Health Cooperative)—Washington only

If you want to...	Go here...
Find Group Health Cooperative (GHC) network providers	Call Group Health Cooperative at (206) 901-4636 or (888) 901-4636. Group Health website. The Group Number is 172300.
Schedule appointments, view medical records, and exchange secure e-mail messages with your doctors	Group Health website. The Group Number is 172300.
Learn more about benefits coverage, the use of non-GHC providers, or finding network physicians or specialists	Call Group Health Cooperative at (206) 901-4636 or (888) 901-4636. The Group Number is 172300.
Contact an experienced, registered nurse for help making health care decisions.	Call the 24-hour Nurse Line at (800) 297-6877. The Nurse Line is available 24 hours a day, seven days a week. For deaf or hard-of-hearing access, call the TTY service at (800) 833-6388. Visit the Benefits site for more information on the Nurse Line.
Get expert medical advice on an important medical decision, such as whether to have surgery or confirming diagnosis of a condition such as cancer or other complex medical issues.	Call the Expert Medical Opinion program, administered by Best Doctors, at (800) 676-1411. Visit the Benefits site for more information on the Expert Medical Opinion program.

HMO plan (Kaiser Permanente)—California only

If you want to...	Go here...
Find Kaiser Permanente network providers	Kaiser Permanente website. In the upper right corner, click Locate our services. The Group Number for Northern California is 603873 and the Group Number for Southern California is 231325.
Schedule appointments, view medical records, and exchange secure e-mail messages with your doctors	Kaiser Permanente website.

If you want to...	Go here...
Learn more about benefits coverage, the use of non-Kaiser Permanente providers, or finding network physicians or specialists	Call Kaiser Permanente at (800) 464-4000. The Group Number for Northern California is 603873 and the Group Number for Southern California is 231325.
Contact an experienced, registered nurse for help making health care decisions.	Call the 24-hour Nurse Line at (800) 676-1411. The Nurse Line is available 24 hours a day, seven days a week. For deaf or hard-of-hearing access, call the TTY service at 711 and provide this number. Visit the Benefits site for more information on the Nurse Line.
Get expert medical advice on an important medical decision, such as whether to have surgery or confirming diagnosis of a condition such as cancer or other complex medical issues.	Call the Expert Medical Opinion program, administered by Best Doctors, at (800) 676-1411. Visit the Benefits site for more information on the Expert Medical Opinion program.

Dental

If you want to...	Go here...
Learn more about your Dental Plus or Dental Basic Plan	Contact Premera Blue Cross at microsoft@premera.com or (800) 676-1411. Group Number: 1000010
Find an in-network dental provider	Premera Provider Directory OR Contact Premera Blue Cross at microsoft@premera.com or (800) 676-1411. Group Number: 1000010

Microsoft CARES employee assistance program (EAP)

If you want to...	Go here...
Learn more about the EAP or seek counseling assistance	Call Wellspring Family Services at (206) 654-4144 or (800) 553-7798. Appointments may also be made through the Microsoft CARES website.

Flexible spending accounts

If you want to...	Go here...
Learn more about your Health Care FSA and/or Dependent Care FSA	Visit the Benefits site OR

	Contact Premera Blue Cross at microsoft@premera.com or (800) 676-1411. Group Number: 1000010
Check the current balance credited to your Health Care FSA and/or Dependent Care FSA	Go to My Dashboard on the Benefits site OR Contact Premera Blue Cross at microsoft@premera.com or (800) 676-1411. Group Number: 1000010

Life insurance

If you want to...	Go here...
Learn more about your life insurance coverage or Evidence of Insurability (EOI)	Contact Prudential at (800) 778-3827 or microsoft@prudential.com. Group Number: 43994
Change or designate a beneficiary	Benefits Enrollment tool

Accidental death & dismemberment (AD&D)

If you want to...	Go here...
Learn more about your AD&D coverage	Contact Prudential at (800) 778-3827 or microsoft@prudential.com. Group Number: 43994
Change or designate a beneficiary	Benefits Enrollment tool

Group legal

If you want to...	Go here...
Learn more about your legal benefits or find an attorney	Call ARAG at (800) 331-3425 Or visit the online ARAG Legal Center . The first time you log on, you'll need to create a user name and password. Your Member ID number is your Microsoft Employee Identification Number (EIN).
Access The Law Guide, which includes education resources and the Do-It-Yourself Legal Documents™.	Visit the online ARAG Legal Center. The first time you log on, you'll need to create a user name and password. Your Member ID number is your Microsoft Employee Identification Number (EIN).

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Administrative information

ERISA requires that certain information be furnished to each participant in an employee benefit plan.

- **Plan name**
Microsoft Corporation Welfare Plan
- **Plan number**
501
- **Plan year**
January 1 to December 31
- **Plan sponsor**
Microsoft Corporation
- **Employer identification number**
91-1144442
- **Type of plan**
Welfare benefit plan providing health and welfare benefits
- **Plan administrator and named fiduciary**
Microsoft Corporation
One Microsoft Way
Redmond, WA 98052-6399
(425) 882-8080
- **Participating employers**

Participating employer name	Company code
Vexcel Corporation	1693
Microsoft Payments, Inc	1888
Microsoft Open Technologies, Inc	1899
Microsoft Operations Licensing Corporation	1654
Microsoft Online, Inc	1548
Microsoft Technology Licensing	1988

- **Source of contributions**
Pre-tax and after-tax employee contributions, and employer contributions
- **Funding**

Health care and dependent care reimbursement benefits	Funded through the employer's general assets
Health, vision, and dental benefits	Funded from the general assets of Microsoft Corporation and employee contributions
Group term life insurance Long-term disability benefits Accidental death and dismemberment benefits	Provided through the purchase of insurance from Prudential Life Insurance Company Provided through the purchase of insurance from Prudential Insurance Company

	Provided through the purchase of insurance from Prudential Insurance Company
Employee assistance benefits	Provided through the purchase of services from Family Services
Group legal services benefits	Provided through the purchase of services from ARAG Group Prepaid Legal

- **Type of administration**

The Plan is administered by Microsoft according to the terms of the plan documents. Under the terms of the plan, Microsoft has the authority to delegate the day-to-day administrative duties to a third party. Microsoft shall have complete discretion to interpret and construe the provisions of the plan options, programs, and policies described in this SPD, to determine eligibility for participation and for benefits, make findings of fact, correct errors and supply omissions. All decisions and interpretations Microsoft made pursuant to the plan options, programs and policies described in this SPD shall be final, conclusive and binding on all persons and may not be overturned unless found by a court to be arbitrary and capricious, or unless found by an independent medical review organization, after external review, to be made in error. Microsoft may delegate this discretionary authority to select service providers.

- **Agent for legal process**

Senior Vice-President, Law and Corporate Affairs
Microsoft Corporation
One Microsoft Way
Redmond, WA 98052-6399

Service of process may also be made upon the Plan Administrator.

Microsoft, as plan administrator and named fiduciary, has reserved the right to amend or terminate the Welfare Plan and any Component Plan, in whole or in part, at any time and for any reason, including contributions to the Plan. See [Right to amend or terminate plan](#) section for more information.



If you have questions regarding the Plan's administration, contact Benefits by e-mail at benefits@microsoft.com or by phone at (425) 706-8853.

False or misleading statements

Any falsification, misrepresentation, or omission of facts or information by you on your enrollment form, benefits enrollment tool, or claim form may result in your loss of coverage and in disciplinary action, up to and including your dismissal from employment at Microsoft. Electronic communications on enrollment or claims are considered written and signed representations. If you lose your coverage, you will not be eligible for any continuation of coverage except to the extent required by the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"). The company retains the right to request confirmation of a dependent relationship by way of birth and/or marriage certificate, domestic partnership affidavit, court documents, and so on, and to recoup any payments made to you in error or in reliance on inaccurate or incomplete information.

Fraud and abuse

Any participant who willfully and knowingly engages in an activity intended to defraud the plan will face disciplinary action that may include Microsoft rescinding the participant's coverage under this plan, the termination of employment, and prosecution. Examples of fraud include falsifying a claim to obtain

benefits or trying to obtain services for someone who is not an eligible dependent or who is no longer enrolled in the plan. The company retains the right to request confirmation of a dependent relationship by way of birth and/or marriage certificate, domestic partnership affidavit, court documents, and so on, to deny coverage for any dependents if such confirmation is not provided, and to recoup any payments made to you in error or in reliance on inaccurate or incomplete information.



If you have questions regarding the Plan's administration, contact Benefits by e-mail at benefits@microsoft.com or by phone at (425) 706-8853.

Right to review

The plan may have any patient examined by an appropriate health care professional when there is a question of fraud or abuse of plan benefits.

How to report suspicious activity to Premera or Group Health Cooperative

If you suspect fraud or abuse, there are several reporting options available to you. All reports are confidential and can be anonymous, if you choose. You are not required to include your name, address, or other identifying information.

For Premera, you may contact the Special Investigations Unit 24 hours a day by leaving a telephone message on the confidential fraud hotline or by mail.

Hotline: (800) 848-0244

Mailing address:

Attention Special Investigations Unit
Premera Blue Cross
7001 220th Street SW
Mail Stop 219
Mountlake Terrace, WA 98043

For Group Health Cooperative, you may contact the Fraud, Waste and Abuse (FWA) Department by e-mail, phone or mail.

E-mail: FWA@ghc.org

Confidential, toll-free hotline: (800) 741-7817

FWA Department: (206) 988-2967

Mailing address:

Group Health Cooperative
Fraud Waste, and Abuse Department
12501 E. Marginal way S., ASB 2
Seattle, WA 98168
Fax: (206) 988-2538

When reporting suspected fraud, please remember to include the names of all applicable parties involved. Specify which person you believe is committing the fraud, identify the dates of service or issues in question, and describe in detail why you believe a fraudulent act may have occurred. If possible, please

include your name and telephone number so Premera or Group Health Cooperative may contact you if they have any questions during their investigation.

Right to amend or terminate plan

Microsoft has reserved the right to amend or terminate the Welfare Plan and any Component Plan, in whole or in part, at any time and for any reason, including contributions to the Plan. Payment of claims incurred at the time of such amendment or termination will not be adversely affected.

Coverage under the Dependent Care Reimbursement Plan, Health Care Reimbursement Plan, and Limited Purpose Health Care Reimbursement Plan will provide reimbursement of Eligible Expenses incurred prior to the date of termination of such Component Plan. Such Expenses will be reimbursed only if the Request for Reimbursement is submitted within ninety (90) days after date of termination.

Participant rights under ERISA

The Employee Retirement Income Security Act (ERISA) provides that all plan participants are entitled to the following:

- Examine, without charge, all documents that govern the plan including insurance contracts and a copy of the latest annual report (Form 5500 Series), which the plan files with the U.S. Department of Labor and is available at the Public Disclosure Room of the Employee Benefits Security Administration, at the plan administrator's office, and at other specified locations, such as worksites
- Obtain, upon written request to the plan administrator, copies of documents that govern the operation of the plan, including insurance contracts, copies of the latest annual report (Form 5500 Series), and updated summary plan descriptions. The administrator may make a reasonable charge for the copies.
- Receive the Summary Annual Report for Microsoft Corporation Welfare Plan. The plan administrator is required by law to furnish each participant with a copy of this summary financial report.
- Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents will have to pay for such coverage. Review this summary plan description and the documents that govern the plan about the rules governing your COBRA continuation coverage rights.

In addition to creating rights for plan participants, ERISA imposes obligations on those responsible for the operation of an employee benefit plan. The people who operate the plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of all plan participants and beneficiaries.

No one, including Microsoft or any other person, may terminate you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

If a claim for a benefit is denied or ignored, in whole or in part, you have the right to know why this was done, to obtain copies of documents that relate to the decision (without charge), and to appeal any denial all within certain time schedules.

Under ERISA, there are steps you can take to enforce the previously stated rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to US\$110 a day until you receive the materials, unless the plan administrator did not send the materials because of reasons beyond the control of the administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds the claim to be frivolous.

If you have any questions about your plan, you should contact Microsoft. If you have any questions about this statement or about your rights under ERISA, contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor that your telephone directory lists, or you can contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.



To access plan administrator information see [Administrative Information](#) or contact Benefits.

Special notice about Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers that offer group insurance coverage generally may not, under federal law restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

This plan complies with these requirements.

Special notice about Women's Health and Cancer Rights Act

As required by the Women's Health and Cancer Rights Act of 1998, the plan provides benefits for mastectomy-related services including all stages of reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy, including lymphedemas. You can contact Benefits or call (425) 706-8853 for more information.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996

Notice of your right to documentation

Prior to the Accountable Care Act (ACA), Federal law allowed employers to apply limitations on paying benefits for preexisting medical conditions for newly hired or newly eligible employees and covered family members. The ACA outlawed this practice as of 1/1/2014 for most health insurance plans. If you terminate employment with Microsoft and begin to work for another employer, you should receive the full benefit for any covered condition once you meet the employer's eligibility criteria and enroll in benefits. Should you need a statement confirming you previously had coverage under a Microsoft plan, you can obtain one by contacting Benefits.

Notice of your special enrollment rights

If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

If you or any of your dependents were covered under a Medicaid or State child health plan and you or your dependents lose eligibility for that coverage, or if you or any of your dependents become eligible for assistance with respect to coverage under this plan due to a Medicaid or State child health plan, you may be able to enroll yourself and your dependents in this plan. However, you must request enrollment within 60 days after your or your dependents' other coverage ends, or within 60 days of becoming eligible for assistance.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, or establishment of a domestic partnership you may be able to enroll yourself and your dependents. However, you must request enrollment within 90 days after the marriage, birth, adoption, or placement for adoption.



To request special enrollment or obtain more information, see the [Life event enrollment](#) section or contact Benefits.

HIPAA Notice of Privacy Practices

Microsoft Corporation welfare plan HIPAA Notice of Privacy Practices

This Notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this Notice carefully.

Effective Date: April 14, 2003, revised effective September 23, 2013

This Notice is from the Microsoft Corporation Welfare Plan (the "Plan"), which is sponsored by Microsoft Corporation. A federal regulation, known as the HIPAA Privacy Rule, requires that a health plan provide detailed notice in writing of its privacy practices. You may receive other notices of privacy practices from other parties that are considered "covered entities" under HIPAA (for instance, physicians, the Living Well Health Center, Kaiser Permanente).

The Microsoft Corporation Welfare Plan includes health care benefits, making it a health plan covered by the HIPAA Privacy Rule. Health care benefits under the Plan include medical, prescription drug, vision and dental benefits. Non-health care benefits under the Plan, including long-term and short-term disability plans, are not covered by the HIPAA Privacy Rule. Microsoft employees and certain other Plan participants may access the health care benefits of the Plan through the online Microsoft Benefits Portal <http://benefits.me.microsoft.com>.

I. OUR COMMITMENT TO PROTECTING HEALTH INFORMATION ABOUT YOU

The HIPAA Privacy Rule requires that we protect the privacy of health information that identifies a participant, or where there is a reasonable basis to believe the information can be used to identify a participant. This information is called "protected health information" or "PHI." Generally, PHI also includes genetic and demographic information, collected from you or created or received by the Plan, that relates to (1) your past, present or future physical or mental health or condition; (2) the provision of health care to you; or (3) the past, present or future payment for the provision of health care to you.

This Notice describes your rights as a health plan participant and our obligations regarding the use and disclosure of PHI. We are required by law to comply with all of the following:

- Maintain the privacy of PHI about you
- Provide you with certain rights with respect to your PHI
- Give you this Notice of our legal duties and privacy practices with respect to PHI
- Comply with the terms of our Notice of Privacy Practices that is currently in effect
- Notify you of a breach of your unsecured PHI

In some situations, federal and state laws provide special protections for specific kinds of PHI and require authorization from you before we can disclose that specially protected PHI. Examples of PHI that is sometimes specially protected include PHI involving mental health, HIV/AIDS, reproductive health, or

chemical dependency. We may refuse to disclose the specially protected PHI or we may contact you for the necessary authorization.

We reserve the right to make changes to this Notice and to make such changes effective for all PHI we may already have about you. For your convenience, a copy of the current Notice is available online through <http://benefits.me.microsoft.com>.

II. HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU

We may use or disclose your PHI under certain circumstances as permitted or required by law or if you (or your authorized representative) give us permission. The following describes the different ways we may use and disclose your PHI.

Treatment: We may use and disclose PHI about you to assist your health care provider in coordinating or managing your health care and related services. For example, we may use or disclose PHI about you to describe and identify the health care providers who are part of a health care network.

Payment: We may use or disclose PHI to pay or deny your claims, to collect premiums, or for the payment activities of your health care providers or your other insurer(s). For example, we may use and disclose PHI to tell you, your health care providers, or your other caregivers whether a particular type of health care service is covered under your policy.

Health Care Operations: We may use and disclose PHI in performing business activities that are called "health care operations." For example, we may use and disclose PHI about you in reviewing and improving the quality, efficiency, and cost of our operations. We may disclose PHI to other entities, if any, in an organized health care arrangement with the Plan. For example, if a health care provider, company, or other health plan that is required to comply with the HIPAA Privacy Rule has or once had a relationship with you, we may disclose PHI about you for certain health care operations of that health care provider or company.

Business Associates: We may contract with individuals or entities known as "business associates" to perform various functions on the Plan's behalf or to provide certain types of services. In order to perform these functions or to provide these services, business associates will receive, create, maintain, use and/or disclose your PHI, but only after they agree in writing with us to implement appropriate safeguards regarding your PHI. For example, we may disclose your PHI to a business associate to administer claims or to provide support services, such as utilization management, pharmacy benefit management or subrogation.

Individuals Involved in Your Care or Payment for Your Care: If you do not object after an opportunity to do so, or if you are incapacitated or if it is an emergency situation, we may disclose to your family member, close friend, or any other person identified by you, PHI about you that is directly relevant to that person's involvement in your care or payment for your care. We may also use and disclose PHI necessary to notify these persons of your location, general condition, or death. State laws will vary, but in many states a teenage minor must consent to use or disclosure of PHI related to his or her mental health,

chemical dependency, HIV/AIDS, or sexual health. Therefore, the Plan may require the child's authorization before releasing PHI to anyone, including his or her parents.

Disaster Relief: We also may share PHI about you with disaster relief agencies such as the Red Cross for disaster relief purposes.

Appointment and/or Service Reminders: We may use your personal information to contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Required by Law: We may use and disclose PHI to the extent required by law.

Incidental Disclosures: Disclosures that are incidental to permitted or required uses or disclosures under HIPAA are permissible so long as we implement safeguards to avoid such disclosures and limit the PHI exposed through these incidental disclosures.

Health Plan Sponsor: Under certain conditions, we may disclose PHI to the Plan Sponsor of this Plan (Microsoft Corporation), but only after it certifies to us that it will take certain steps to protect the confidentiality of your PHI.

Public Health or Oversight Activities: We may use and disclose PHI to authorized persons to carry out certain activities related to public health. We may disclose PHI to a health oversight agency to monitor the health care system, government health care programs, and compliance with certain laws

Abuse, Neglect, or Domestic Violence: We may disclose PHI in certain cases to proper government authorities if we reasonably believe that a participant has been a victim of domestic violence, abuse, or neglect.

Lawsuits and Other Legal Proceedings: We may use or disclose PHI when required by a court order, administrative agency order, subpoenas, discovery requests, or other lawful process, when efforts have been made to advise you of the disclosure or to obtain an order protecting the information requested.

To Law Enforcement or to Avert a Serious Threat to Health or Safety: Under certain conditions, we may disclose PHI to law enforcement officials. We may use and disclose your PHI under limited circumstances when necessary to prevent a threat to the health or safety of a person or to the public.

Coroners, Medical Examiners, Funeral Directors: We may disclose PHI to a coroner or medical examiner to identify a deceased person and determine the cause of death, or to funeral directors, as authorized by law, so that they may carry out their jobs.

Organ and Tissue Donation: If you are an organ donor, we may use or disclose PHI to facilitate an organ, eye, or tissue donation and transplantation.

Research: We may use and disclose PHI about you for research purposes under certain limited circumstances.

Specialized Government Functions: Under certain conditions, we may disclose PHI for military activities, national security, or other specialized government functions.

Workers' Compensation: We may disclose PHI to the extent necessary to comply with laws that provide benefits for work-related injuries or illness.

Disclosures Required by HIPAA Privacy Rule: We are required to disclose PHI to the Secretary of the United States Department of Health and Human Services when requested by the Secretary to review our compliance with the HIPAA Privacy Rule.

Other Uses and Disclosures: All other uses and disclosures of your PHI will be made only with your written permission (an "authorization"). We generally may not use or disclose your PHI for marketing purposes or sell your PHI without your authorization. If you have given us authorization to use or disclose your PHI, you may later take back ("revoke") your authorization at any time, except to the extent we have already acted based on your permission.

Genetic Information: We may not use or disclose PHI that is genetic information for underwriting purposes.

III. YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU

Under federal law, you have the following rights regarding PHI about you. Unless otherwise noted, you may exercise any of these rights by contacting the Privacy Operations Official or Privacy Official identified in Section V below.

Right to Request Restrictions: You have the right to request additional restrictions on the use of your PHI for treatment, payment, and health care operations, or on the disclosure of your PHI to individuals involved in your care. We are not required to agree to your request.

Right to Receive Confidential Communications: If you tell us that disclosure of your PHI could endanger you, you have the right to request in writing that we communicate your PHI to you in a certain manner or at a certain location. For example, you may request that we contact you at home, rather than at work. We are required to meet only reasonable requests.

Right to Inspect and Copy: You can request the opportunity to inspect and receive a copy of your PHI in certain records that we maintain. We may charge you reasonable fees for the cost of providing a copy.

Right to Amend: You have the right to request that we amend your health plan PHI if you give us an appropriate reason for the request.

Right to Receive an Accounting of Disclosures: You have the right to request an "accounting" of certain disclosures that we have made of your PHI. This is a list of disclosures made by us after April 13, 2003, during a specified period of up to six years, other than disclosures made for treatment, payment, and health care operations; to family members or friends involved in your care; to you directly; pursuant to an authorization of you or your personal representative; for certain notification purposes (including national security, intelligence, and law enforcement purposes); of a "limited data set" in compliance with our

policies and procedures for this kind of data; or incidental to otherwise permitted or required uses and disclosures. The first list you request in a 12-month period will be free, but we may charge you for our reasonable costs of providing additional lists in the same 12-month period. We will tell you about these costs, and you may choose to cancel your request at any time before costs are incurred.

Right to a Paper Copy of this Notice: You have a right to receive a paper copy of this Notice at any time. Please email Benefits@Microsoft.com or call 425-706-8853 for a paper copy.

IV. COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us. To file a complaint with us, contact our Privacy Operations Official. You may also file a complaint directly with the Office for Civil Rights of the United States Department of Health and Human Services ("OCR"). We will not retaliate or take action against you for filing a complaint.

V. PRIVACY OPERATIONS OFFICIAL AND PRIVACY OFFICIAL CONTACT INFORMATION

If you have questions, you may contact our Privacy Operations Official or Privacy Official at the following addresses and phone numbers:

Privacy Operations Official

Julie Sheehy
Director, Global Health & Wellness
Microsoft Corporation
One Microsoft Way
Redmond, WA 98052
(425) 722-4083

Privacy Official

Fred Thiele
Senior Director, Global Benefits
Microsoft Corporation
One Microsoft Way
Redmond, WA 98052
(425) 421-4459

CHIP Notice

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **(877) KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free (866) 444-EBSA (3272).

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2015. You should contact your State for further information on eligibility –

ALABAMA – Medicaid	COLORADO – Medicaid
Website: http://www.myalhipp.com Phone: (855) 692-5447	Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: (800) 221-3943
ALASKA – Medicaid	
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/	

Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): (907) 269-6529	
FLORIDA – Medicaid	GEORGIA – Medicaid
Website: https://www.flmedicaidtplrecovery.com/ Phone: (877) 357-3268	Website: http://dch.georgia.gov/ Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: (424) 656-4507
INDIANA – Medicaid	MONTANA – Medicaid
Website: http://www.in.gov/fssa Phone: (800) 889-9949	Website: http://medicaidprovider.mt.gov/member Phone: (800) 694-3084
IOWA – Medicaid	NEBRASKA – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: (888) 346-9562	Website: www.ACCESSNebraska.ne.gov Phone: (855) 632-7633
KANSAS – Medicaid	NEVADA – Medicaid
Website: http://www.kdheks.gov/hcf/ Phone: (800) 792-4884	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: (800) 992-0900
KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: (800) 635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: (603) 271-5218
LOUISIANA – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331	Medicaid Website: http://www.state.nj.us/humanservices/

Phone: (888) 695-2447	dmahs/clients/medicaid/
MAINE – Medicaid	Medicaid Phone: (609) 631-2392
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: (800) 977-6740 TTY (800) 977-6741	CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: (800) 701-0710
MASSACHUSETTS – Medicaid and CHIP	NEW YORK – Medicaid
Website: http://www.mass.gov/MassHealth Phone: (800) 462-1120	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: (800) 541-2831
MINNESOTA – Medicaid	NORTH CAROLINA – Medicaid
Website: http://www.dhs.state.mn.us/id_006254 Click on Health Care, then Medical Assistance Phone: (800) 657-3739	Website: http://www.ncdhhs.gov/dma Phone: (919) 855-4100
MISSOURI – Medicaid	NORTH DAKOTA – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: (573) 751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: (800) 755-2604
OKLAHOMA – Medicaid and CHIP	UTAH – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: (888) 365-3742	Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: (866) 435-7414

OREGON – Medicaid	VERMONT– Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: (800) 699-9075	Website: http://www.greenmountaincare.org/ Phone: (800) 250-8427
PENNSYLVANIA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: http://www.hs.state.us/hipp Phone: (800) 692-7462	Medicaid Website: www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: (800) 432-5924 CHIP Website: www.coverva.org/programs_premium_assistance.cfm CHIP Phone: (855) 242-8282
RHODE ISLAND – Medicaid	WASHINGTON – Medicaid
Website: www.ohhs.ri.gov Phone: (401) 462-5300	Website: www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: (800) 562-3022 ext. 15473
SOUTH CAROLINA – Medicaid	WEST VIRGINIA – Medicaid
Website: http://www.scdhhs.gov Phone: (888) 549-0820	Website: www.dhhr.wv.gov/bms/Medicaid%Expansion/Pages/default.aspx Phone: (877) 598-5820, HMS Third Party Liability
SOUTH DAKOTA - Medicaid	WISCONSIN – Medicaid and CHIP
Website: http://dss.sd.gov Phone: (888) 828-0059	Website: https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: (800) 362-3002

TEXAS – Medicaid	WYOMING – Medicaid
Website: https://www.gethipptexas.com/ Phone: (800) 440-0493	Website: https://wyequalitycare.acs-inc.com Phone: (307) 777-7531

To see if any more States have added a premium assistance program since July 31, 2015, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor

Employee Benefits Security Administration

www.dol.gov/ebsa

(866) 444-EBSA (3272)

OMB Control Number 1210-0137 (expires 10/31/2016)

U.S. Department of Health and Human Services

Centers for Medicare & Medicaid Services

www.cms.hhs.gov

(877) 267-2323, Menu Option 4, Ext. 61565

Summary Annual Report for Microsoft Corporation Welfare Plan

This is a summary of the annual report for the MICROSOFT CORPORATION WELFARE PLAN, EIN 91-1144442 for the period January 1, 2014 through December 31, 2014. The annual report has been filed with the Department of Labor's Pension and Welfare Benefits Administration, as required under the Employee Retirement Income Security Act of 1974 (ERISA).

Microsoft Corporation has committed itself to pay certain claims incurred under the terms of the plan.

Insurance Information

The plan has contracts with ARAG Insurance Company, Wellspring Family Services EAP, and Prudential Insurance Company of America, to pay certain medical, dental, disability, life, accidental death and dismemberment, and travel and accident claims incurred under the terms of the plan. The total premiums paid for the plan year ending December 31, 2014 were \$65,133,792.

Your Rights to Additional Information

You have the right to receive a copy of the full annual report, or any part thereof, on request. The items listed below are included in that report:

1. Information on payments to service providers.
2. Insurance information including sales commissions paid by insurance carriers.

To obtain a copy of the full annual report, or any part thereof, write or call the office of the Plan Administrator: MICROSOFT CORPORATION, ONE MICROSOFT WAY, REDMOND, WA 98052-6399, (425) 882-8080. The charge to cover copying costs will be \$5.00 for the full annual report or \$.25 per page for any part thereof.

You also have the right to receive from the plan administrator, on request and at no charge, a statement of the assets and liabilities of the plan and accompanying notes, or a statement of income and expenses of the plan and accompanying notes, or both. If you request a copy of the full annual report from the plan administrator, these two statements and accompanying notes will be included as part of that report. The charge to cover copying costs given above does not include a charge for the copying of these portions of the report because these portions are furnished without charge.

You also have the legally protected right to examine the annual report at the main office of the plan (MICROSOFT CORPORATION, ONE MICROSOFT WAY, REDMOND, WA 98052-6399) and at the U.S. Department of Labor in Washington, D.C., or to obtain a copy from the U.S. Department of Labor upon payment of copying costs. Requests to the Department should be addressed to: Public Disclosure Room, N5638, Pension and Welfare Benefit Program, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.